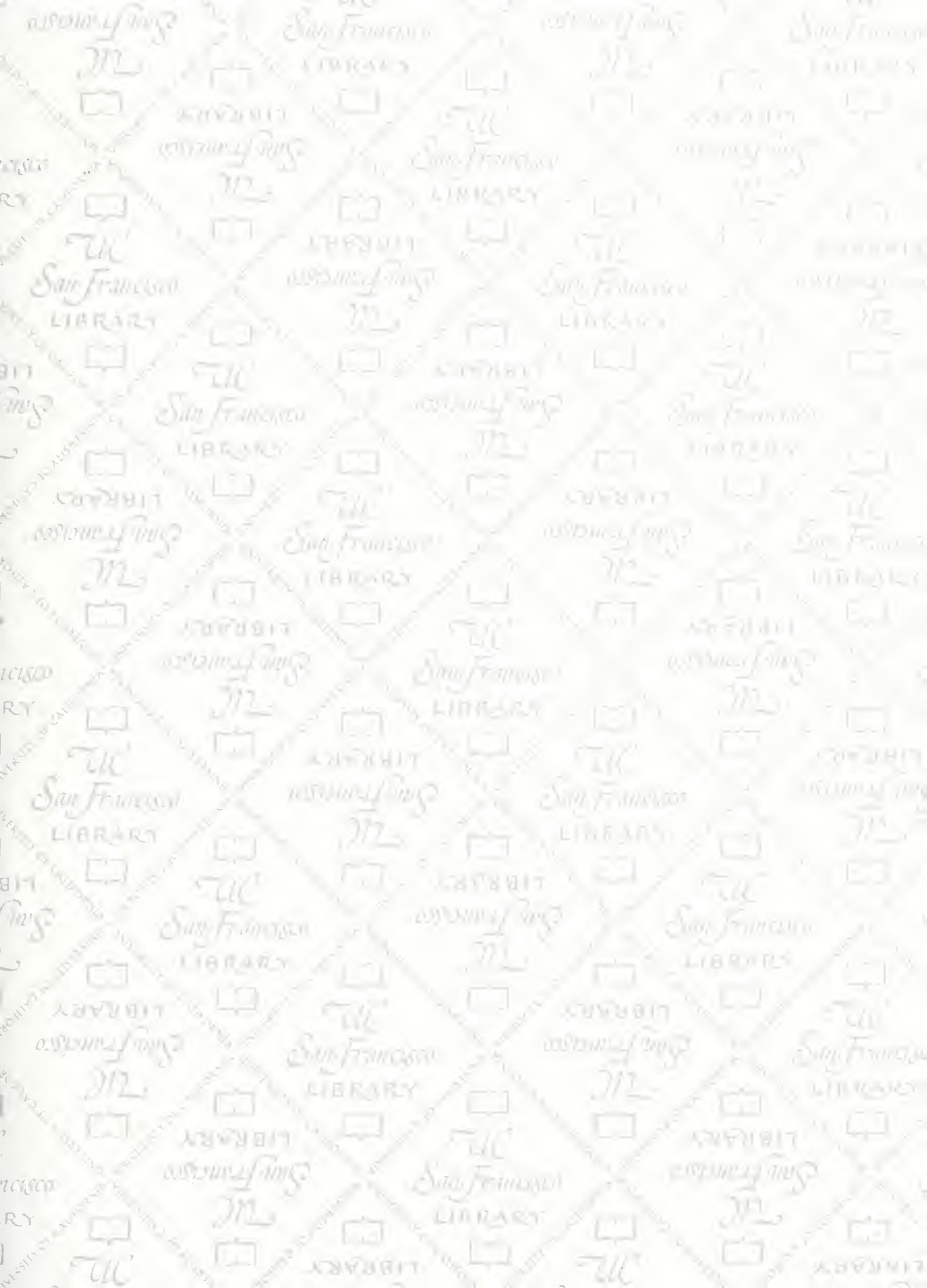
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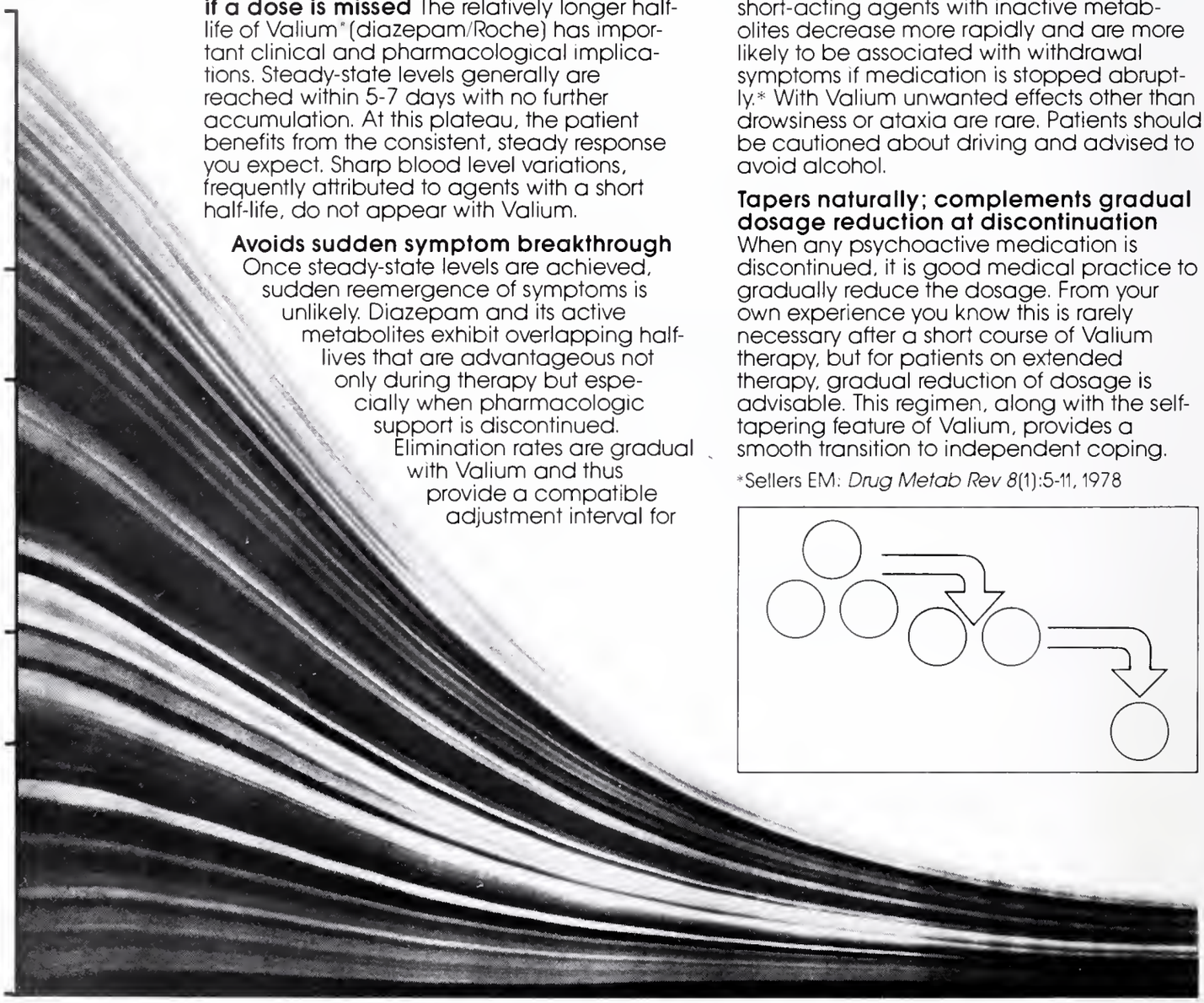
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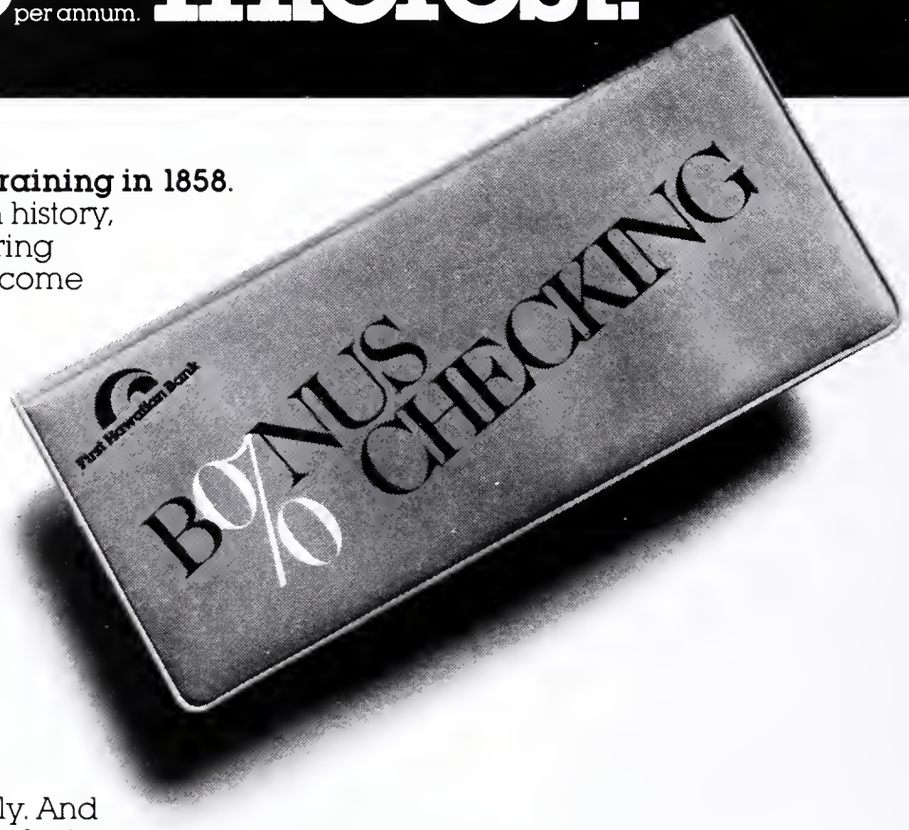
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1973-77 Cancer Incidence in Hawaii, with Special Reference to Trends Since 1968-72 for Certain Sites

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• *Age-adjusted average annual cancer incidence rates by sex and ethnic group for 1973-77 are presented. The marked inter-ethnic variation in incidence by site is noted. A comparison with cancer incidence rates in 1968-1972 revealed rather consistent trends across ethnic groups for several sites. Among men and women, stomach cancer rates largely declined, while lung cancer rates largely increased. Among women, cancer rates increased for breast and corpus uteri, and decreased for cervix uteri in all ethnic groups. Among men, prostate cancer rates increased in all ethnic groups, with the possible exception of Japanese.*

It is well established that cancer incidence varies greatly among different population groups.[1] Nowhere is this better illustrated than among the several ethnic populations of Hawaii.[2] Current opinion holds that most of the variation in cancer incidence among different populations is due to environmental rather than genetic factors.[3] Recognition of the importance of environmental factors in determining cancer incidence has led to the realization that much cancer can be prevented if the responsible environmental factors can be identified and controlled.

Trends in cancer incidence in the United States also vary for different population groups, with rates rising among males, and most rapidly among non-white males, but decreasing among both white and nonwhite females between 1947-48 and 1969-71.[4] Studies of time trends in site-specific cancer incidence may sometimes suggest etiologic clues, and are also useful in estimating future needs in cancer treatment and rehabilitation. This paper presents selected 1973-77 cancer incidence rates in Hawaii by sex and ethnicity and also examines trends in cancer incidence since 1968-72 for certain common sites.

From the *Epidemiology Program, Cancer Center of Hawaii, University of Hawaii and the †Hawaii Tumor Registry, Hawaii State Department of Health.

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Data Collection

All data are those collected by the Hawaii Tumor Registry (HTR), which was established by the Hawaii Medical Association in 1960 and became a member of the Surveillance, Epidemiology and End Results (SEER) group of the Biometry Branch of the National Cancer Institute in 1973.

The HTR relies upon the active cooperation and assistance of physicians, hospital administrators, and others throughout the State for the quality and completeness of its data. More than 94 percent of the cases in the registry have been microscopically confirmed. A death certificate was the sole source of information in less than 1% of the cases.

The primary site of the tumor is classified by the Hawaii Tumor Registry according to the International Classification of Diseases for Oncology (ICDO), adopted in 1976 by the World Health Organization. Only invasive malignancies were included in the calculation of incidence rates; *in situ* cancers were excluded. The cancer sites selected for inclusion in this paper are as follows: Mouth-pharynx (ICDO 143-146, 148, 149), esophagus (ICDO 150), stomach (ICDO 151), colon (ICDO 153), rectum (ICDO 154), liver and biliary tract (ICDO 155 and 156), pancreas (ICDO 157), larynx (ICDO 161), lung (ICDO 162), hematopoietic and reticuloendothelial systems (ICDO 169), female breast (ICDO 174), cervix uteri (ICDO 180), corpus

uteri (ICDO 182), ovary (ICDO 183), prostate (ICDO 185), bladder (ICDO 188), kidney (ICDO 189), and thyroid (ICDO 193).

Where time-trend comparisons were made, two 5-year time periods were examined: 1968-72 and 1973-77. The age-, sex- and ethnic-specific population denominators used in the calculation of cancer incidence rates were obtained from the Research and Statistics Office of the Hawaii State Department of Health, and were based on the ongoing Health Surveillance Program which samples approximately 2% of Hawaii's population yearly. Because rates based on small numbers of cases tend to be unstable, comparisons were not made when the cases in an ethnic-sex group were fewer than 10 for either 5-year period.

In order to compare rates among the ethnic populations, which have noticeably different age structures, the rates were age-adjusted to the World Standard Population using the direct method.[1]

Only persons who were residents of Hawaii at the time of diagnosis were included in these analyses. For the cases, ethnicity was based on that stated in the medical records. For the rate denominator populations, ethnicity was based on the stated ethnic group of parents. For this paper, only persons of pure Japanese, Chinese and Filipino ethnicity were included. The Caucasian group included Portuguese, and the Hawaiian group included all those with any stated Hawaiian ancestry.

Results

Table 1 shows the average annual age-adjusted cancer incidence rates for each site, sex and ethnic group during 1973-77. The marked inter-ethnic variation in rates for most sites is obvious. Of particular note are the following: esophagus, where Hawaiian men had 7.2 times the incidence of Caucasian men; stomach, where Hawaiian men had 4.5 times the incidence rate of Filipino men; lung, where Hawaiian men had 4 times the incidence rate of Filipino men; breast, where Hawaiians had 3.3 times the incidence rate of Filipinas; and bladder, where Caucasian men had more than 4 times the incidence rate of Hawaiian men. For all cancer sites combined, exclusive of squamous and basal cell skin cancer, Hawaiian men had the highest age-adjusted incidence rate, which was twice as high as that for Filipino men. Hawaiian women had an overall cancer incidence rate which was 2.2 times that of Filipino women. It is also interesting to note that the ranking by ethnic group for breast, corpus uteri and ovarian cancer is almost identical, with Hawaiian and Caucasian women having the highest rates, followed by Chinese, Japanese, and Filipino women.

Table 2 shows the change in age-adjusted cancer incidence for common sites between 1968-72 and 1973-77 expressed as a percentage increase or decrease of the 1968-72 rate. Cancer sites included in this table are those for which the number of cases in both 5-year time periods was sufficient to give reasonable confidence that any trend observed was not simply due to random fluctuation. For colon, rectum and bladder there is little consistency in the direction of the changes among the different ethnic-sex groups. However, certain patterns for other sites do emerge. For stomach cancer, (Figure 1) women in all ethnic groups showed a substantial decrease in incidence rates as did Caucasian and Japanese men. Cancer of the lung (Figure 2) showed an increase in incidence rates for all ethnic-sex groups except Chinese men and Filipino men and women. This increase was particularly large for Hawaiian, Caucasian and Japanese women,

TABLE 1. Age-adjusted average annual incidence per 100,000 of cancer by site, sex and ethnic group, 1973-77

	Males					*Females*				
Cancer Site	Cau	Jpn	Chi	Hwn	Fil	Cau	Jpn	Chi	Hwn	Fil
Mouth-Pharynx	11.6	3.1	2.2	9.1	5.6	7.9	1.0	0.7	5.3	4.1
Esophagus	2.5	4.1	6.1	18.1	6.5	1.9	0.6	0.6	2.7	1.0
Stomach	12.7	33.1	10.4	37.7	8.3	5.0	15.1	8.3	18.8	6.1
Colon	25.5	26.5	29.3	13.9	16.4	17.8	18.8	21.5	14.2	9.7
Rectum	13.8	21.0	16.4	10.5	13.3	8.6	9.1	8.7	9.5	9.4
Liver-Biliary	5.0	9.5	12.1	12.6	13.0	3.5	6.1	6.8	11.7	4.0
Pancreas	8.4	8.1	7.8	10.7	6.5	6.5	4.3	6.5	7.4	1.7
Larynx	8.0	3.5	1.6	5.7	1.9	1.3	0.4	0.0	1.5	0.5
Lung	64.1	36.3	31.5	98.5	24.4	24.0	11.4	23.7	41.8	18.0
Hemo-R.E. system	11.8	8.0	6.0	18.8	10.7	9.0	7.3	5.8	11.3	11.9
Breast	—	—	—	—	—	86.6	47.1	55.3	88.1	26.3
Cervix	—	—	—	—	—	9.5	6.3	7.8	17.9	6.6
Corpus Uteri	—	—	—	—	—	35.3	19.8	28.5	35.1	15.1
Ovary	—	—	—	—	—	9.5	7.0	7.4	11.1	4.7
Prostate	58.4	33.9	27.7	40.3	30.3	—	—	—	—	—
Bladder	22.7	9.7	8.4	5.7	6.5	3.9	3.3	1.1	6.4	3.6
Kidney	10.9	5.7	2.6	5.4	4.6	3.0	1.9	3.5	4.5	2.9
Thyroid	3.8	4.6	7.3	6.4	6.6	6.6	6.3	12.0	17.2	16.8
All sites*	327	231	198	354	176	274	183	218	342	159

*Excludes squamous and basal cell skin cancer

TABLE 2. Changes in average annual age-adjusted cancer incidence per 100,000 between 1968-72 and 1973-77, by sex and ethnic group for selected sites*

Cancer Site	Males					Females				
	Cau	Jpn	Chi	Hwn	Fil	Cau	Jpn	Chi	Hwn	Fil
Stomach	−20%	−10%	+20%	+23%	+9%	−23%	−34%	−28%	−35%	‡
Colon	+6	+17	+5	−7	−4	−20	−7	+21	−5	−37
Rectum	+4	+27	−14	+12	−15	−26	−11	‡	‡	‡
Lung	+27	+5	−16	+30	−2	+33	+37	+18	+111	−17
Breast	—	—	—	—	—	+9	+12	+9	+33	+45
Cervix	—	—	—	—	—	−26	−18	−51	−3	−59
Corpus Uteri	—	—	—	—	—	+29	+38	+52	+15	+14
Prostate	+34	+31	+66	+57	+103	—	—	—	—	—
Bladder	+15	−19	−11	−40	+86	−26	0	‡	‡	‡
All Sites †	+15	+5	−1	+12	+9	−2	+1	+1	+23	−5

*Increase or decrease expressed as a percentage of the 1968-72 rate
‡Fewer than 10 cases reported in 1968-72 and/or 1973-77
†Excludes squamous and basal cell skin cancer

FIG. 1.—*Comparison of average annual age-adjusted stomach cancer incidence per 100,000 for 1968-72 versus 1973-77*

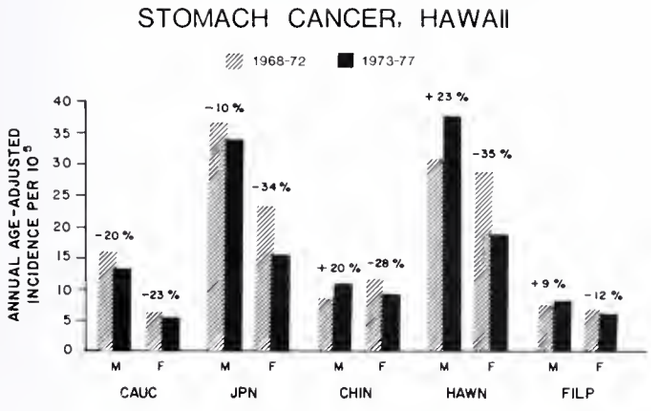
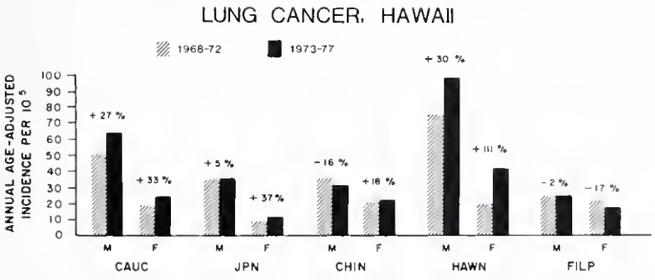


FIG. 2.—*Comparison of average annual age-adjusted lung cancer incidence per 100,000 for 1968-72 versus 1973-77*



and only slightly less for Hawaiian and Caucasian men.

The only cancer sites for which the temporal change in incidence rates showed a consistent pattern were all sex-related. They include cancer of the breast (Figure 3), cervix, uterine corpus (Figure 4) and prostate. Of these sites, only cancer of the cervix showed a general decrease in incidence rates between 1968-72 and 1973-77.

For cancer of the prostate, a special problem in interpretation of the temporal change in incidence rates arose. This cancer has come under special study by certain Honolulu pathologists, and can be found to occur as a latent lesion in many glands which are carefully examined after removal at autopsy.[5] Such latent cancers of the prostate which are detected in the course of these special studies are reported to the Hawaii Tumor Registry and thus included in the routine incidence data. Because almost all of these latent cases found at autopsy were reported after 1973, they inflated the rates for the 1973-77 period. We have, therefore, done a separate analysis for this site, using only cases which were diagnosed prior to autopsy. As can be seen in Table 3, this analysis

FIG. 3.—*Comparison of average annual age-adjusted breast cancer incidence per 100,000 for 1968–72 versus 1973-77*

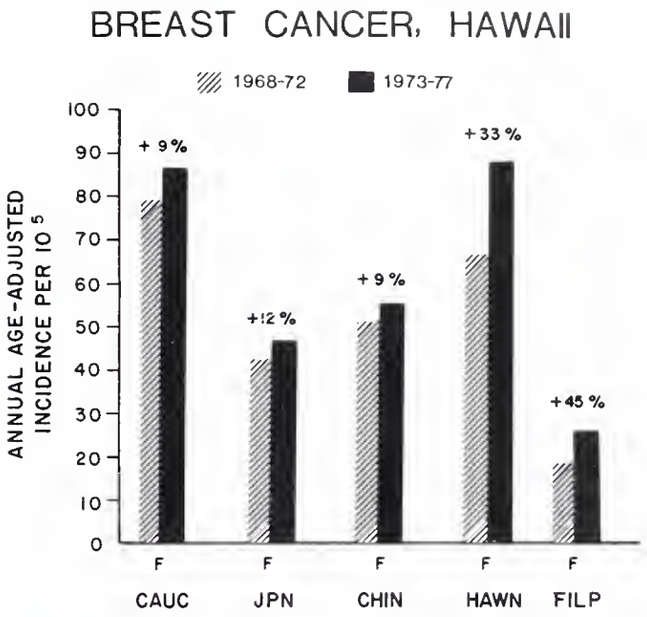


FIG. 4.—*Comparison of average annual age-adjusted uterine corpus cancer incidence per 100,000 for 1968–72 versus 1973-77*

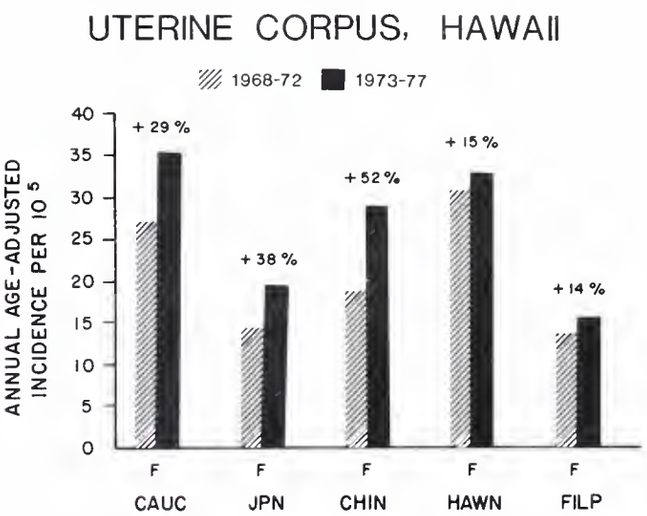


TABLE 3.—*Average annual age-adjusted incidence per 100,000 for cancer of the prostate diagnosed prior to autopsy, 1968-72 and 1973-77*

	PROSTATE CANCER		
ETHNIC GROUP	RATE IN *1968-72*	RATE IN *1973-77*	% *CHANGE**
Caucasian	43.7	55.0	+26
Japanese	25.5	24.3	−5
Chinese	16.7	24.8	+49
Hawaiian	25.6	34.7	+36
Filipino	14.6	28.2	+93

*Increase or decrease as a percentage of the 1968-72 rate

does substantially change the age-adjusted incidence rates for prostate cancer in 1973-77, and there is no longer evidence for an increasing incidence rate among Japanese, although substantial increases are still evident for the other ethnic groups.

It is interesting to note that between 1968-72 and 1973-77, there was little change in cancer incidence rates for all cancer sites combined among several of the ethnic-sex populations (Table 2). Particularly among Chinese of both sexes and Caucasian and Japanese women, the changes were minimal. Japanese men likewise show no substantial change once the influence of autopsy-diagnosed prostate cancer is removed. However, for Hawaiians of both sexes and for Caucasian and Filipino men, there is evidence for a significant increase in total cancer incidence during the time period examined.

Discussion

In respect to cancer etiology, the inter-ethnic variations in incidence observed in Hawaii are of great interest and importance. The scope of this paper, however, does not allow a detailed discussion of the many inter-ethnic variations; instead, we will concentrate on time trends for those cancer sites where a largely consistent pattern of increase or decrease in incidence was observed between 1968-72 and 1973-77.

Stomach cancer incidence rates have been steadily decreasing in the U.S. for many years.[4] The findings of this paper for all females and for Caucasian and Japanese men are in agreement with a downward trend in stomach cancer incidence in Hawaii. Although the etiology of stomach cancer is still in question, certain dietary factors which may increase risk have been identified, such as pickled vegetables and dried/salted fish.[6,7] Nitrosamines formed from the ingestion of precursor secondary amines and nitrites[8] which are found in these foods are suspected of being the carcinogens responsible for stomach cancer related to diet.[9] Low risk for stomach cancer has been found to be associated with greater consumption of fruit[7] and vegetables, particularly raw vegetables.[6,7,10] It is not clear at this time whether the observed changes in stomach cancer incidence rates in Hawaii are related to changes in consumption of these or other food items.

Lung cancer mortality rates among men in the U.S. have been increasing for most of this century. Among U.S. women, lung cancer mortality has been increasing since about the mid-1950's,[4] and in recent years, the rate of increase in lung cancer mortality has been greater among women than men.[11] The findings in this study are consistent with these observations except for Chinese men and Filipinos of both sexes, who showed decreasing lung cancer incidence rates. Cigarette smoking is, of course, the most important risk factor for lung cancer.[12] Our findings on the cigarette smoking patterns of the ethnic groups in Hawaii do indicate that Chinese and Filipino men smoke substantially less than men of other ethnic groups,[13] but no information is available on time-trends in smoking habits.

Between the First National Cancer Survey in 1937-39 and the Third National Cancer Survey in 1969-71, breast cancer incidence rates in U.S. women showed only a modest increase, most of which was among non-whites.[4] The data in Hawaii, however, indicate that breast cancer incidence increased substantially in all ethnic groups between 1968 and 1977. A small portion of this increase may be due to increased screening activity by both mammography and breast self-examination, but this seems an unlikely explanation for all of the increase since *in situ* cancers, which are often detected by screening, were not included in these incidence rates. Furthermore, the greatest percentage increases were for Hawaiian and Filipino women, both of which groups were underrepresented in the population screened by Honolulu's Breast Cancer Detection Demonstration Project (Fred Gilbert, M.D., personal communication). The etiology of breast cancer is still unknown, but increased risk has been related to such factors as large body size,[4] late age at first pregnancy[15] and possibly dietary fat consumption.[16] Also of interest are reports which suggest an increased risk as a result of long-term use of post-menopausal estrogens.[17,18] The relationship of these factors to the increased incidence of breast cancer in Hawaii is not known, but a case-control study among Caucasian and Japanese women is nearing completion and may provide some answers.[19]

Among U.S. whites, but not among U.S. non-whites, there was a slight upward trend in incidence rates for cancer of the corpus uteri

between the Second and Third National Cancer Surveys.[4] However, in the past decade many studies have documented the increasing incidence of endometrial cancer, particularly in West Coast populations, and related this to increased use of postmenstrual estrogens.[20] It has recently been estimated that approximately 15,000 excess cases of endometrial cancer occurred in U.S. women between 1971 and 1975 as a result of postmenopausal estrogen use.[21] The increased incidence rates observed for all ethnic groups in this study are consistent with observations in other U.S. populations and can probably be explained, at least in part, by increased postmenopausal estrogen use. Obesity is another identified risk factor for endometrial cancer[22] and may operate through the same pathway as postmenopausal estrogens, since conversion of adrenal androstenedione to estrone (an estrogen) has been shown to occur in peripheral adipose tissue.[23]

The decline of invasive cervical cancer incidence observed among all ethnic populations is in agreement with long-term trends in the U.S. as a whole.[4] This decreasing incidence is probably ascribable to increased screening activities over the past three decades, as indicated by a recent case-control study.[24] However, no randomized prospective trial to evaluate the effectiveness of such screening has ever been conducted.[25]

Prostate cancer incidence rates have been increasing among both whites and nonwhites in the U.S. for several decades.[4] This trend would appear to be evident also in Hawaii, with the possible exception of Japanese men. Since the etiology of prostate cancer remains obscure, the reasons for this increasing incidence are unknown. Certain factors, such as sexual activity,[26] dietary fat[27] and occupational exposures,[28] have been tentatively associated with the disease, but none as yet satisfactorily explain the rising incidence rates.

It is disturbing that certain groups, particularly Hawaiians of both sexes and Caucasian men, have shown a substantial increase in total cancer incidence rates between 1968-72 and 1973-77. Much of this increase can be attributed to increasing rates of lung cancer, prostate cancer, breast cancer, cancer of the corpus uteri and bladder cancer (for Caucasian men). Epidemiological studies have been successful in identifying cigarettes as the major cause of lung cancer and a cause of bladder cancer;[12] asbestos as an important cause of lung cancer;[29] and postmenopausal estrogens as a cause of some endometrial cancer.[21] Such findings have pointed the way toward primary prevention of much cancer. For other important cancer sites such as breast and prostate, however, the etiology and thus the means for primary prevention continue to remain uncertain.

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Poor physical state leads to problems in the deep . . .

Dysbarism Associated with Alcohol Abuse: A Case Report

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Fishing is an essential element in Hawaiian society. The select group of Hawaiian diving fishermen have acheived notariety over the years because of their often daring underwater activities. Unfortunately, these divers are too frequently the victims of dysbaric diving diseases. A case is reported which typifies many of the diving habits that have led to the reputation of the diving fishermen and which also illustrates the untoward outcome which too frequently befalls these intrepid underwater fishermen.

Gathering food from the sea has been an integral part of Hawaiian life ever since the first Polynesian immigrants arrived on Hawaii's pristine shores. Over the years, however, one group of Hawaii's fishermen have repeatedly distinguished themselves by their daring exploits; these are Hawaii's diving fishermen.

For hundreds of years, these diving fishermen were limited to relatively shallow underwater excursions lasting only as long as a single breath of air could be held. Although the early European explorers who visited the islands commented on the skill and endurance of the diving fishermen, little is known about the medical problems associated with their underwater activities. Presumably, the primary hazards were toxic marine envenomations and ingestions, occasional shark attacks, coral cuts, and similar types of problems.

With the importation of SCUBA to Hawaii in the early 1950's, new health problems soon confronted the diving fishermen. The sudden accessibility to previously untapped fishing areas provided a strong monetary incentive to take greater chances than ever. Similarly, a striking disparity between the capability of the new underwater technology and the awareness of safe diving practices resulted in the all too frequent occurence of dysbaric diving diseases.

During the last 30 years, the diving fishermen and black coral divers have constituted the greatest proportion of diving casualties which have occurred in Hawaii. In recent years a greater effort has been made to promulgate diving safety throughout the State by University of Hawaii Sea Grant programs. There is some indication that these attempts have resulted in heightened awareness of safe diving practices among local divers. Unfortunately, serious diving accidents continue to occur among the Hawaiian diving fishermen.

A case treated by the Navy Undersea Medicine Service at Pearl Harbor typifies the legendary style and, regrettably, the too often outcome of what has become known as "Hawaiian diving". This case not only illustrates multiple unsafe diving practices, but it also exemplifies the spectrum of decompression sickness which can afflict a single diver.

Case Report

A 27-year-old Hawaiian fisherman made 3 successive SCUBA dives to depths estimated at 50, 100, and over 200 feet; on the last dive he may have gone as deep as 250-275 feet. He wore neither a depth gauge nor a diving watch. He estimated his bottom time as about 30 minutes on each dive. The depth estimates were based on prior experience of diving in the same area. There was no significant surface interval between the dives. On the last dive he ran out of air

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at a depth estimated to be about 200 feet, and he made a rapid emergency free ascent. His missed decompression from these dives was estimated to be at least 300 minutes.

When he reached the surface, his diving partners immediately noted he was confused and agitated. He was assisted into the boat and transported to the Maui Memorial Hospital Emergency Room, arriving there about 3 hours after surfacing from the last dive.

In the emergency room he was reported to have a blood pressure of 120/100 and a pulse rate of 120. He was noted to be dyspneic, diaphoretic, agitated, and disoriented. General physical examination was reported as grossly within normal limits except for the neurological exam, where he was reported to have a right-sided flaccid hemiplegia. Arterial blood gas analysis on 14 liters oxygen per minute by oronasal mask revealed a pH 7.38, $p0_2$ 47, and $pC0_2$ 33. An intravenous infusion of D5W was started, and he was given dexamethasone 10 mg, by intravenous push. Arrangements were made to transfer him to the Navy recompression chamber at the Submarine Escape Training Tank (SETT), Pearl Harbor.

During the aerovac flight to Oahu the patient was maintained on oxygen by mask. Some time during the flight he also developed severe pain in his right shoulder. Although the flight was believed to have been at low altitude, as per routine, the exact cruising altitude is unknown.

Upon arrival at the SETT recompression chamber, about 5 hours after the accident occurred, the patient was noted to be aware of where he was and that he had "the bends", but he was otherwise somewhat confused, agitated, and poorly cooperative to examination. On specific questioning, however, it was determined that he was a heavy smoker and had had a cough, substernal chest pain, and possible bronchitis for several weeks. He reported having had only 2 hours sleep in the previous 2 days and drinking heavily for the past several days. It was also learned that he had been diving as a fisherman for about one year, but he had never received any formal training or certification.

Physical examination revealed pulse and blood pressure to be 100 and 120/100, respectively, and respirations 18. In general, he appeared to be in moderate distress, although he was not noted to be dyspneic at this time. There were no overt clinical signs of the pulmonary overinflation syndrome, and the positive physical findings were confined to the neurological exam. The cranial nerves were grossly normal to the extent that examination was possible. Sensation to pinprick was absent below the umbilicus. Insofar as he cooperated, strength appeared to be intact in the head, neck, and upper extremities. In the lower extremities, however, he manifested a total flaccid paralysis on the right side and marked weakness on the left side, so that he could not overcome gravity. The deep tendon reflexes were full and equal in the upper extremities, but they were absent below the waist. Superficial cutaneous reflexes were not elicited, and there was no Babinski sign.

After completing a rapid physical examination, the patient was given an injection of hydrocortisone hemisuccinate, 1000 mg, intravenously, and recompressed to 60 FSWG. The possibility of the patient having sustained a cerebral air embolism was considered, but the diving medical officer in attendance elected to treat with U.S. Navy Treatment Table 6, instead of 6A, because of the lengthy time interval since the accident.

Essentially no improvement was noted during the first 3 oxygen periods at 60 FSWG. The treating physician decided to extend the treatment table at 2.8 ATA, and, eventually, e total of 9 oxygen periods at this pressure were completed. During this time the patient was extremely restless and fought the oxygen mask. He was given diazepam, 10 mg, intravenously, to calm him down enough that treatment could be continued. After several hundred milliliters of intravenous fluid had produced no urine output, he was catheterized. Only 50 cc of very dark amber urine returned, which had a specific gravity of 1.028. A blood count revealed a hematocrit of 61% and a white blood cell count of 32,000 with 87% polymorphonuclear leukocytes. The blood urea nitrogen and electrolytes were normal. The blood sugar was 129 mg%, but he was receiving an intravenous infusion of D5/0.9% NaCl solution.

During recompression, additional intravenous fluid was administered (principally normal saline solution), and he later voided a total of 500 cc via the foley catheter. A further 4 mg dose of dexamethasone was given mid-way through the treatment. At the 30 FSWG stop the patient became so agitated and uncooperative that he had to be restrained.

Periodic re-examination during recompression revealed no significant changes. Because of the lack of improvement and having reached a near maximal UPTD oxygen dose, the treatment table was not extended at 1.8 ATA. The total time of this recompression was 8 hours and 46 minutes.

At the conclusion of initial recompression treatment the patient's mental status had deteriorated to the point that he was essentially completely uncooperative for neurological evaluation. At one point, he did state that his right shoulder pain had resolved. It was noted, however, that there was minimal spontaneous movement of both legs and that the deep tendon reflexes had returned to normal in the lower extremities. He displayed frequent nonpurposeful movement of both arms, with intermittant

posturing suggestive of a decorticate state. No Babinski sign could be clearly elicited. Sensation to pinprick appeared absent below T 9-10, but accurate testing was difficult because of the patient's clouded mental state. Similarly, there appeared to be left-sided facial weakness, but it was impossible to perform a careful evaluation of the cranial nerves.

The laboratory analysis revealed a urine specific gravity of 1.026 and moderate glucosuria. Hematological assessment included a hemoglobin of 20, hematocrit of 60.3%, and white blood cell count of 29,000 with a normal differential analysis. The qualitative platelet count was normal. Other laboratory analysis included: blood urea nitrogen 17, glucose 177, sodium 141, chloride 105, potassium 4.9, carbon dioxide 21, PTT and PT (patient/control) 28/27 and 12.5/11.3, respectively. Arterial blood gas analysis on supplemental oxygen at 5 liters/minute by oronasal mask showed a pH 7.36, $p0_2$ 143, and $pC0_2$ 37. The chest x-ray and electrocardiogram were normal.

During the subsequent several hours, the patient developed definite left lower facial paresis and marked left hemiparesis, being able to barely move the left elbow and the fingers of the left hand. He was noted to have no anal sphincter tone and to be incontinent of stool. He also developed a left hemianopsia but demonstrated no nystagmus. Sensory evaluation showed absence of pain (pinprick) and vibration sensation and loss of position sense below T 9-10. His mental status remained very clouded, and he continued intermittently to demonstrate decorticate posturing.

On the morning following admission to the MICU, a CAT scan was obtained and showed a radiolucency in the right parietal region along with the suggestion of multiple infarctions in both the right frontal and parietal lobes. It was elected to retreat the patient with hyperbaric oxygen. A U.S. Navy Treatment Table 6 was conducted but appeared to produce no changes in the patient's condition, and he was returned to the MICU.

Over the ensuing 24 hours the patient's sensorium seemed to clear significantly and there was a suggestion of increased strength of the proximal musculature of the left arm. A further hyperbaric oxygen (HBO) therapy table was undertaken (90 minutes oxygen at 2.4 ATA), but this treatment produced no notable improvement. It was elected not to pursue further HBO therapy.

A few days later the patient was transferred to Queen's Medical Center (QMC) after manifesting scant improvement at TAMC. His left hemianopsia substantially resolved, and his mental status cleared, although he had poor recall of the event of the preceding few days. His affect was notable flat. Cognitive function testing revealed substantial deficits in his ability to perform simple mathematical calculations, which was believed to represent a significant change from his pre-accident mathematical ability. His hematological parameters normalized, but he was noted to have mild scleral icterus and an elevated SGPT. In view of a strong history of alcohol abuse and otherwise normal liver function tests, these signs of hepatic dysfunction were interpreted as representing alcoholic liver disease. The SGPT normalized a few days later.

He failed to show significant improvement at QMC, and after several days he was transferred to the Rehabilitation Hospital of the Pacific (RHP) with the following deficits: flaccid paraplegia, marked paresis of the left uper extremity (flaccid except for being slightly able to flex the left elbow and to wiggle the fingers of the left hand), mild lower left facial palsy, mild left hemianopsia, bilateral anesthesia from L 1 down and left sided anesthesia from about T 4 to L 1, absence of anal sphincter tone, bladder catheter dependence, and the presence of a flat affect and poor cognitive ability.

At the RHP, the patient's course was marked by little improvement. After 11 days at that facility he signed out against medical advice, and he has not been seen since.

Comment

This man is believed to have suffered multiple forms of dysbarism, ranging from pain-only bends of the right shoulder; probable pulmonary decompression sickness ("the chokes"); neurological decompression sickness (DCS) of large segments of the thoracic, lumbar and sacral spinal cord and of the brain; and possibly cerebral air embolism.

Typically, cerebral decompression sickness should produce myriad lacunar infarcts not readily visible with computerized axial tomography; however, the fulminant nature of this patient's decompression sickness and the absence of other stigmata of the pulmonary over-inflation syndrome suggests that the cerebral infarcts noted on CAT scan were due to DCS and not air embolism. The possibility of combined gaseous and non-gaseous lipid/cellular aggregate emboli should also be considered. Whether this man goes on to develop dysbaric osteonecrosis remains to be determined.

The disparity between the initial emergency room report of a right hemiplegia and the eventual triplegia, the right arm being the only functional limb, cannot be reconciled. Given the ultimate outcome, the possibility of a recording error on the emergency room record should be considered, although this cannot be verified.

This case graphically illustrates the untoward outcome of the capricious diving practices which have characterized some of Hawaii's diving population. It is hoped that continued commu-

nity diving safety awareness and education programs will minimize and, hopefully, altogether prevent further diving accident catastrophes such as this.

Acknowledgment

The authors are indebted to the personnel at the several facilities providing care for this patient for allowing us to review treatment records.

The opinions and assertions contained herein are the private ones of the authors and are not to be construed as official or reflecting the views of the Navy Department or naval service at large.

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Aloha, Mike

It wasn't long ago that Michael Halberstam, M.D., spoke before our Association about federalism vs. medicine from his unique vantage as a practicing cardiologist and syndicated medical columnist in Washington, D.C.

Now Mike lies dead, shot by a professional burglar he accosted in his home. Mike's death proves particularly painful for we who identified with his quest for excellence in medicine, teaching, and writing. Mike had a rare talent for reducing complicated medical issues to clear and interesting stories. His violent death comes as another rude reminder that even the best and brightest are no less vulnerable to vicious persons who would blast the flesh. The bizarre account of how Mike, mortally wounded, later ran down the assailant with his car, speaks volumes as a final act of human outrage.

Could caution and restraint have saved Mike? Would gun control prove helpful? Perhaps penal revision, including certain and summary execution of those guilty of assault by firearms (whether "insane" or not)? If there are any answers, they aren't simple. Meantime, medicine has lost a leader, and a nation of patients has lost something priceless: a physician whose greatest joy was *explaining* things about sickness. Aloha, Mike.

JMC

Just Tell the Truth

"The lady at Medicare says your bill is too high," wails the patient. "They can't pay it, when it's not reasonable." This recurring theme arises from the failure of insurance carriers to forthrightly explain the limits of their coverage. This rings particularly true of Medicare reimbursements for "reasonable" charges.

My patient knows that Medicare pays only 80% of the "reasonable" charges, but only with persistence will she learn that they define this as the 75th percentile of an elusive *base year*. But the "base year" is always more than a year ago, so what's called "reasonable" today actually means anything less than 75% of the fees of 1979, or before. Conversely, anything higher than this becomes un-"reasonable." When my patient receives 80% of this 75%, her check will be about 60% of 1979 fees. Meanwhile, my 1981 charges reflect inflated costs of doing business.

It's unfair for carriers to conceal these simple truths, and unconscionable to imply that the physician's current fee is not "reasonable." As small proprietors of labor-intensive, service businesses, we are exposed to 1981 costs on all fronts.

Physicians would appreciate a simple, honest statement from Medicare: "In periods of high inflation, this *supplementary* insurance may not cover more than one-half of reasonable current medical costs."

JMC

Quick Fix

An ingenious example of business efficiency comes to light following a Government Accounting Office investigation of the Medicare Part B carrier in Illinois (EDS Federal). It seems that in an effort to reduce its backlog of unpaid claims and complaints, EDS systematically destroyed letters of complaint from beneficiaries, and purged their computer system of all complaints more than 90 days old.

JMC

Monkey Business

Thomas Edison warned that, "There is far more danger to public monopoly than there is to private monopoly, for when the government goes into business, it can always shift the losses to the taxpayers. The government never really goes into business, for it never makes ends meet, and that is the first requisite of successful business. It just mixes a little business with politics, and no one ever gets a chance to find out what actually is going on."

Ponder, friend, that even shifting all losses to the taxpayers, our government in 1980 was left with a *sixty billion dollar* shortfall. This debt was covered by simply printing sixty billion extra paper "dollars." Alas, these inflated the money supply by 13%, thus diluting the value of all existing money: presto, 13% inflation. Don't blame the Arabs.

JMC

A Layman Speaks Out On The Hospital Hazard Nobody Ever Writes About

As any young worshipper at the shrine of rock music knows, Elvis Presley died on August

16, 1977, of what the press then reported as a cardiac arrhythmia. On that date I became briefly unconscious and was rushed to Kaiser Emergency Clinic. Diagnosis: arrhythmia. With every cardiac bed at Kaiser Hospital filled, I was transferred by ambulance—its siren silenced—to Kuakini Hospital. There some shortage of beds also existed. I was put in a "monitor bed" in a four-bed room that also held non-cardiac patients.

There I encountered the hospital hazard nobody seems to write about: "entertainment." At each bedside hung a panel that controlled, among other things, selection and volume of radio. In theory, these limit sound to the bedside. In practice, the volume can be increased to reach neighboring beds. The volume was high that terrible day. My wardmates were tuned in to Honolulu radio stations, all playing Presley records non-stop. I have always hated the Elvis school of non-music. Now the sound was unbearable, for with each song a kind of subliminal message came through: This man just died of an arrhythmia. Arrhythmias can cause death. Therefore, I will probably die.

(In fairness to Kuakini Hospital, I point out that this radio onslaught would not have occurred in the regular cardiac care unit.)

My encounter with Elvis was only one of many hospital incidents, experienced or witnessed, in which unwanted "entertainment" was force-fed into the ears of patients. Consider:

Scene One: I visit a young mother in the maternity section of Queen's Medical Center. The young mother's personally owned radio is sending forth rock 'n roll. In the next bed, another woman holds her pillow tightly over her ears as she tries to rest.

Scene Two: My sister-in-law lies in a two-bed room in St. Francis Hospital. Her neighbor's TV blares out the ersatz excitement of a game show. Almost shouting over the tumult, I try to talk to my sister-in-law. I can barely hear her weak responses. A young resident enters and attempts to question her. He, too, shouts inquiries and strains to hear answers. Two days later, my sister-in-law died. She loved quiet; her spirit had always been nourished by hymns and the chorales of Bach, yet her last days were spent amid the aural assaults of game shows and soap operas.

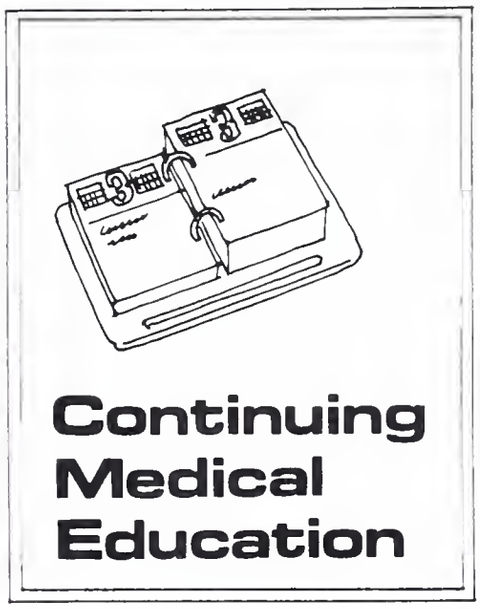
A friend tells of a stay in a four-bed ward in this same hospital a few years ago. One roommate kept both radio and TV at high volume while her visiting boyfriend strummed his guitar. No one in charge quieted the cacophony.

The irritations of electrical sound are two-edged. The viewing-listening patient often annoys his neighbor; the considerate patient will miss his favorite diversion. My husband was a patient at Kaiser Hospital a few weeks ago. Solicitous of his seriously ill roommate, he deliberately refrained from viewing his cherished *Nova* and *Cosmos* programs.

Consider, now, a contrasting scene. Recently scheduled for surgery in a Melbourne, Australia, hospital, I chose, for economy and companionship, a four-bed ward. There, close to each bed, were a small television set and controls for radio and piped-in music. None functioned except through comfortably padded, rubber-encased earphones. I recall with a kind of tender amusement the night before all four of us faced surgery. After some congenial Aussie-American chit-chat, each of us repaired to our television set, there to calm pre-operation jitters with the balm of the tube. Four small sets glowed with separate programs. Neither glare nor sound from one person's bed annoyed her neighbors. A friendly quiet prevailed.

Earphones with their use enforced can restore the calm and peace that is the right of every hospital patient. (Pillow speakers, alas, are not always kept on pillows!) Light weight earphones for personally owned radios and tape players are inexpensive and comfortable; their use should be required. The large, costly, glaring color TV sets in hospitals are unnecessary. Surely less money would provide smaller, black-and-white, earphone-equipped sets. The patient who cherishes Vivaldi should not have rock and disco forced upon him. Conversely, the sports fan or disco addict need not suffer through his roommate's symphony concert. Individual earphones can make entertainment subject to individual preference. The privacy of the ear, long disregarded, must be restored to our hospitals.

Catherine A. Lee
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ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, First Thursday, 12:45 p.m. and Fourth Tues. 12:30 p.m. w/Maui Mem. Hsp. Held on Oahu at Am. Cancer Society main conf. room, 200 N. Vineyard, Honolulu.

John A. Burns School of Medicine

1. Dept of Medicine
 A. Case Conferences, Second and Fourth Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 B. Grand Rounds, First and Third Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 C. Endocrinology Grand Rounds, Third Wednesdays, 5:30-6:30 p.m., Queens University Tower, Room 506.
 D. Hematology Grand Rounds, Second and Fourth Mondays, 12:30-1:30 p.m., Queens University Tower, Room 721.
 E. Cardiology Grand Rounds, First and Third Tuesdays, 5:30-6:30 p.m., Queens University Tower, Room 508.
 F. Infectious Disease Grand Rounds, Second and Fourth Tuesdays, 5:00-6:00 p.m., Queens Nalani I Conference Room.
 G. Dermatology Grand Rounds, Second Wednesday, 7:30-8:30 a.m. Queens, Queen Emma Clinic.
 H. Pulmonary Grand Rounds, Second and Fourth Thursdays, 4:30-5:30 p.m., Queens Kamehameha Auditorium.
2. Division of Nuclear Medicine
 A. Technical aspects of Nuclear Medicine, Second Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506, 1½ credits.
 B. Rounds, Fourth Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506.
3. Dept. of Obstetrics and Gynecology
 A. Grand Rounds, Wednesday 7:30-8:30 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
4. Division of Orthopaedics
 A. Fracture Conference, Tuesdays, 5:00-6:00 p.m., Queens University Tower, Room 618.
 B. Shriners Hospital Conference, Tuesdays, 7:15-9:15 a.m., Shriners Hospital.
5. Dept. of Pediatrics
 A. Grand Rounds, Thursdays 8:00-9:00 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 B. Pediatric Conference, Mondays 12:45-1:45 p.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 C. Pediatric Infectious Disease Conference, Thursdays, 12:30-1:30 p.m., Kapiolani-Children's Medical Center, Third Floor Conference Room.
 D. Neonatal Ground Rounds, Fridays, 8-9:00 a.m., Kapiolani-Children's Medical Center, Administrative Conference Room.
6. Dept. of Psychiatry
 A. Grand Rounds, Fridays 8:00-9:30 a.m., Queens University Tower, Room 618.
7. Dept. of Surgery
 A. Grand Rounds, First, Second and Third Saturdays, 7:30-9:00 a.m., rotating hospitals.
 B. Statistical M and M, last Saturday, 7:30-9:00 a.m., rotating hospitals.
 C. Journal Club, First and Third Tuesdays, 6:00-8:00 p.m., Queens University Tower, Room 620.
 D. Medical-Surgical G.I. Rounds, Second Tuesday, 7:00-8:00 a.m., Queens University Tower, Room 506.
8. Depart of Family Practice
 A. Conf., Wednesdays, 8-9:00 a.m. Kaiser 4th Floor Conf. Room.
 B. Conf., Thursdays, 12-1:00 p.m. Kaiser 4th Floor Conf. Room.
9. Department of Physiology
 A. Dept. Conf., Wednesday, 4:30-5:30 p.m. BioMed T-210.
10. University of Hawaii, John A. Burns School of Medicine Grand Rounds, Third Thursday, 4:30-6:00 p.m., Queen's University Tower, Room 618 or BioMed Building.
11. HI Oncology Group, one Monday a mnth., 12:30-1:30 p.m., The Cancer Center, 1236 Lauhala St., 4th Floor Conference Room.

Federation of Emergency Medicine-Maui

1. **Cardiology for the Emergency Physician.** Every Monday, 9-10:00 a.m.-Maui Memorial Hsp. Conf. Rm #1. (For spec. topics or further infor contact: Federation Office (808) 244-7629, or Dr. C. T. Mitchell, (808) 244-9056.
2. **Journal Club in Emerg. Medicine.** 2 hrs. Cat. I. MMH Conf. Rm. #1.
 A. **11/17/80**—Anals of Emerg. Med. (Sept 1980) 9-11 a.m.-Abstracts of ER Med. (Aug 1980)
 B. **12/22/80**—Anals of Emerg. Med. (Oct 1980) 9-11 a.m. Abstracts in ER Med. (Sept 1980)

Hawaii Thoracic Society

1. Pulmonary Med., Clinical case presentations & current research in pul. med. with U of H sinclair Chest Club. Third or Fourth Wed., ea month, 7:30 p.m.-9:30 p.m. For further info contact: Rosemary Respicio, B.S.N. at (808) 537-5966.

Hickam Clinic

1. Clinical Correlation Conference, First Thursday, 11:00 a.m.
2. Didactic—our staff, Second Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, Third Thursday, 11:00 a.m.
4. Radiology Conference, Fourth Thursday, 11:00 a.m. (Contact Aurora Macapinlac, M.D., M.C., 449-5770)

Hilo Hospital

1. Orthopedic Conference, First Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, Second Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, Third Friday, 12:30-1:30 p.m.
5. C.P.C., Second Friday, 12:30-1:30 p.m.
6. Visiting Professor's Program

Kaiser Hospital

1. Medicine Grnd. Rnds. Every Tues. 8 a.m. Pac. Aud. 1 hr. Cat. I.
2. Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. I.
3. OB/Ped. Perinatal Mortality Conf. Last Tues. ea. mnth. 8:00 a.m. 1 hr. Cat. I.
4. Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. I.
5. Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. I.

(Contact CME Dept.-Kaiser for further information)

Kapiolani-Children's Medical Center

1. Pediatric Grnd. Rnds. Every Thursday, 8-9:00 a.m. Aud.
2. Pediatric Conf. Mondays, 12:45-1:45 p.m. 2nd Floor Aud.
3. Neonatal Grnd. Rnds., Fri. 8-9:00 a.m., Conf. Rm. B.
4. Pediatric Infectious Disease Conf., Thursdays, 12:30-1:30 p.m. 3rd Floor Conf. Rm.
5. Ob-Gyn Conf. Tues. 1-2:00 p.m. Aud.

First—Didactic Presentation
Second—Perinatal-Neonatal Topics
Third—Obstetrics Topics
Fourth—Gyn Topics

6. Tumor Brd.—Oncology Conf. First and Third Fri. 1-2:00 p.m., Aud.

Kuakini Medical Center

1. Department of Opthalmology Meeting, First Tuesday, 1:00-2:00 p.m.
2. G. I. Conference, Second Tuesday, 8:00-9:00 a.m.
3. Department of Medicine Meeting (Statistical), Fourth Tuesday, 1:00-2:00 p.m.
4. Nephrology Conference, Second Wednesday, 8:00-9:00 a.m.
5. Oncology Conference, First, Third, & Fourth Thursday, 7:30-8:30 a.m.
6. Pulmonary Conference, First Thursday, 1:00-2:00 p.m.
7. Surgical Conference, First & Second Friday, 12:45-1:45 p.m.
8. Surgical Mortality & Morbidity Conf., Fourth Friday, 12:45-1:45 p.m.
9. Visiting Professors Programs
10. Oncology Conference (Tutor Oncologist), Second Wednesday, 7:30-8:30 a.m.

Maui Memorial Hospital

1. Thurs. Conf. 7-8:00 a.m. Staff Dining Rm.
 1st—Dept. of Medicine
 2nd—Dept. of Surgery
 3rd—Dept. of OB/GYN
 4th—Dept. of Pediatrics
 5th—Elective
2. Tumor Brd. every Mon. 12:15-1:15 p.m.—Tumor Conf. Telephone Task Force—Third Tues. 12:15-1:15 p.m.
3. Dept. of Emergency Med., Third Mon., 7-8:00 a.m.
4. Diagnostic Radiology—Fourth Tues., 12-1:00 p.m.
5. SFH-UH Hematology Conf., Third Thursday, 12:30 p.m.Sullivan-4 Classroom.
6. SFH-UH Surgical Grand Rounds, First, Second, & Third Fridays, 7:30 a.m., Sullivan-4 Classroom.
7. Visiting Professor Programs (for further infor call CME office at St. Francis).

The Queen's Medical Center

1. ENT Conferences, First and Second Fridays, 7:30 a.m., Small Dining Room.
2. Medical Conferences, Every Friday, 8:00 a.m., Kam Auditorium.
3. Ob/Gyn Conferences, Second and Fourth Mondays, 1:00 p.m., Kam Auditorium.
4. Ophthalmology Conference, Fourth Tuesday, 5:00 p.m., Queen Emma Eye Clinic.
5. Orthopaedic Conferences, Every Wednesday, 7:00 a.m., Kam Auditorium.
6. Pathology Conferences, Every Wednesday, 7:30 a.m., Surgical Conference Room.
7. Pediatric Grand Rounds, Fourth Thursday, 12:30 p.m., Nalani I Conference Room.
8. Surgical Trauma Conference, Second Tuesday, 4:30 p.m., Kam Auditorium.

 Basic Science Lectures, Every Wednesday, 7:15 a.m., Queen's University Tower, Room 618.

St. Francis Hospital

1. SFH-UH Tumor Conf., Every Monday, 7:30 a.m. Sullivan-4 Classroom.
2. SFH-UH Nephrology Conf., First Monday, 1:00 p.m. Sullivan-4 Classroom.
3. SFH-UH Endocrine Conf., last Monday, 12:30 p.m. Sullivan-4 Classroom.
4. EENT Meeting, First Tuesday, 7:00 a.m., Sullivan-4 Classroom.
5. SFH-UH Hematology Conf., Third Thursday, 12:30 p.m. Sullivan-4 Classroom.
6. SFH-UH Surgical Grand Rounds, First, Second, & Third Fridays, 7:30 a.m., Sullivan-4 Classroom.
7. Visiting Professor Programs (for further infor call CME office at St. Francis).

Straub Clinic & Hospital

1. Straub Professional Seminar meets the Second Tuesday of each month, from 5:00-6:30 p.m. in the Credit Union Meeting Room (2nd Floor, Credit Union Bldg).
2. Surgical Mortality and Morbidity Conference meets every Fourth Thursday of each month, from 7:00-8:00 a.m. in the Doctors' Dining Room.
3. Cardiac Surgery Conference meets the Third Tuesday of each month, from 4:30-5:30 p.m. in the Doctors' Dining Room.
4. Department of Anesthesiology meets the Second Tuesday of each month from 7:00-8:00 p.m. in the Doctors' Dining Room.
5. Community Peripheral Vascular Conference meets the Fourth Thursday of each month from 5:00-6:30 p.m. in the Doctor's Dining Room.
6. Visiting Professor Program meets monthly from 7:00-8:00 a.m. in the Doctors' Dining Room.
7. Urology Inservice meets every other month on the Third Friday from 8:00-9:00 a.m. in the Doctors' Dining Room.
8. Neuropathology Clinical Correlation Conference meets the Third Thursday of each month from 7:30-8:30 a.m. in the Straub Morgue.
9. OB-GYN Pathology meets every Fourth Monday of each month from 12:30-1:30 p.m. in the Administration Conference Room (ACR).
10. Urologic Pathology meets every First Monday of each month from 8:00-9:00 a.m. in the Doctors' Dining Room.
11. Friday Noon Conference meets every Friday of each month from 12:30-1:30 p.m. in the Doctors' Dining Room.

*Note: All conferences are subject to change. Monthly calendar will be available upon request.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—Second Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Miscellaneous

HMA Maternal and Perinatal Mortality Study Cmte. First Monday ea. month-7:00 p.m. 320 Ward Ave., S 200. Cat. I on hr. for hr. basis.

SPECIAL EVENTS

Feb. 1, 8, 1981	Clinical Allergy. J. A. Burns Schl of Med., U of H. Honolulu, HI. Held: Hyatt Regency, Maui. Contact: Dee Chang, (808) 947-8573 or 948-7457.
Feb. 2, 8, 1981	"Instrumentation in the Clinical Lab.: An International Perspective." Sponsor: World Assoc. of Societies of Pathology & International Cntr. for Hlth. Ed. Contact: Robt. Schmidt, M.D., International Cntr. for Hlth Ed, P.O. Box 3109, Lihue, Kauai, HI 96766, (808) 245-2121. Held: Kauai Surf Htl. Kauai. 25 hrs. Cat. I.
Feb. 4, 6, 1981	Office Dermatology for the Primary Care Physician. J. A. Burns Schl of Med., 1960 E-West Road, Honolulu, 96822. Co-sponsor: Hi Chapt. AAFP. Held at Kahala Hilton Htl, Honolulu. 3 days, 12 hrs.
Feb. 6, 7, 1981	Genetic Environmental Interaction In Diabetes Mellitus, CCECS, 2530 Dole St. Honolulu 96822, Contact: Wayne Hamasaki, (808)

	948-8244. Held: 9am-5pm at Sheraton-Waikiki Htl, Waikiki.
Feb. 15, 21, 1981	"Infectious Diseases: Recent Advances in Treatment & Prevention." Spons: American Brd. of Med. Microbiology; Nat'l. Regis. of Microbiologists, & International Cntr. for Hlth Ed. Contact: Robert Schmidt, M.D., International Cntr. for Hlth Ed, P.O. Box 3109, Lihue, Kauai, HI. Held: Kauai Surf Htl. 25 hrs. Cat. 1.
Feb. 21, 1981	"What's Right with the World"—a Wellness Seminar. Spons: HMA & HCMS Auxiliary. 8am-3pm. 5½ hrs. Cat. I. Held: Ala Moana Htl., Hibiscus Ballroom, Honolulu. Contact: Susan Spangler (808) 734-2925.
Feb. 21, 28, 1981	Practical Neurology for Primary Phys. U of Wash. Schl. of Med., CME SC-50, Seattle 98195. Held: Kona Surf, Kona, HI.
Feb. 21, 28, 1981	Metabolism & Endocrinology. U of Wash CME SC-50, Seattle 98195. Co-sponsor-Wash State Med. Assn. Held: Kona Surf, Kona, HI. 7 days, 49 hrs.
Feb. 23, 25, 1981	Postgraduate Course in Vascular Surgery. Am Col of Surgeons/co-sponsor J. A. Burns Schl of Med., U of H. Held at Hawaiian Regent Hotel, Honolulu.
Mar. 2-6, 1981	Surgical Diagnosis & Therapy Phil Thorek Pstgrd. Courses, 850 Irving Park, Chicago, IL 60613. Hels-Kauai 20 hrs. Cat. 1
Mar. 16-20, 1981	Sports Medicine Course-U of HI J. A. Burns Schl of Med. Box CE-CCECS, 2530 Dole St. Honolulu 96822. Cospons: AmAcadFam-Phys. Held: Princess Kaiulani Htl, Waikiki, Contact: Wayne Hamasaki, (808) 948-8244. 18 hrs. Cat. I.
Apr. 4, 12, 1981	Calif. Soc. of Anesthesiologists. Dr. Norman R. Catron, Exec. Dir., 100 S. Ellsworth Ave., San Mateo, CA 94401. Held: Kauai Surf, Kauai, HI.
Apr. 4, 11, 1981	Current Concepts in OB/BYN. U of Wash CME SC-50, Seattle 98195. Co-spons: Wash State Med. Assn. Held: Kona Surf, Kona, HI. 49 hrs. Cat. 1.
Apr. 4, 5, 1981	Fourth Annual Acute Care Seminar. Queen's Medical Center, 1301 Punchbowl St., Honolulu, 96813. 12 hrs. Cat. I. Contact: CME Dept. Queen's (808) 547-4484.
Apr. 10, 17, 1981	Med. Imaging in Kauai. Am. Coll of Med Imaging, Box 27188, L.A., CA 90027. Held: Kauai Surf Htl., Kauai, HI. 24 hrs. Cat. I.
Apr. 11, 18, 1981	Drug Therapy & Infectious Diseases. U of Wash., CME SC-50, Seattle, 98195. Held: Kona, HI. 49 hrs. Cat. I.
Apr. 11, 18, 1981	Office Management of Chronic Pain. U of Wash, CME SC-50, Seattle 98195. Co-spons: Wash State Med. Assn. Held: Wailea Beach Htl., Maui, HI. 49 hrs. Cat. I.
Apr. 25, May 2, 1981	Diagnostic & Therapeutic Skills in Internal Med. U of So. Calif Sch of Med., 2025 Zonal Ave, L.A., CA. Held: Mauna Kea Beach Htl, Kamuela, HI. 5 days, 29 hrs. Cat. I.
Apr. 25, May 2, 1981	Emergency Medicine, U of So. Calif Sch of Med. 2025 Zonal Ave., L.A., CA. Held: Royal Lahaina Resort, Maui, HI. 5 days, 29 hrs. Cat. I.
May 2, 9, 1981	Pathology. U of So. Calif Sch of Med., 2025 Zonal Ave, L.A., CA. Held: Mauna Kea Beach Hotel, Kamuela, HI. 5 days, 30 hrs. Cat. I.
May 5, 10, 1981	Recent Advances in Surg: Emergency Surg Problems. White Mem Med Cntr, 1720 Brooklyn Ave, L.A., 90033. Cospons: Loma Linda U Sch of Med. Held: Ilikai Htl, Waikiki & Wailea Bch. Htl, Maui, HI. 24 hrs. Cat. 1.
May 9, 16, 1981	Management of the Surg. Patient, Stanford U Sch of Med., Stanford 94305. Held: Mauna Kea Bch Htl, Kamuela, HI 96743. 6 days, 25 hrs. Cat. I.
May 18, 21, 1981	Hawaii CME Sem. Loma Linda U Sch of Med, Anderson & Barton Rds., Loma Linda, CA. 92350. Held: Mauna Kea Bch Htl, Kamuela, HI. 4 days, 16 hrs. Cat. 1.
May 18, 22, 1981	Med Oncology Review. Am Coll of Phys., 4200 Pine St. Philadelphia, PA 19104. Cospons: U of H Sch of Med. Held: Honolulu. Contact: CME, U of H, 1960 E-West Rd., Honolulu 96822, (808) 948-7457.
May 23, 30, 1981	Allergy & Immunology. U of Wash Cont Med Ed, SC-50, Seattle, Wash 98195. Cospons: Wash St. Med Assn. Held: Wailea Beach Htl, Maui, HI. 7 days, 49 Hrs. Cat. 1.

OUT OF STATE

For information on any out-of-state programs or courses, refer to September 3, 1980 Supplement to JAMA or call the HMA Office.



Friday, December 12, 1980
HMA CONFERENCE ROOM

PRESENT:
Drs. Winn, Catts, Lum, Hindle, Bell, Chinn, Fong, Don, Chun-Hoon, Lumeng, Shirasu, Bruce, Cahill, Wigle, Fu, Newman, McNamee, Char, Goto, Saiki, Dang, Mr. V. Thomas Rice, and Mrs. May Kim. HMA Staff present were: Messrs. Won, Jones, and Leineweber; Mmes. Kendro and Wong.

CALL TO ORDER:
The meeting was called to order by President Winn at 6:00 p.m.

MINUTES:
The minutes of the previous meeting were approved as circulated.

REPORT OF THE SECRETARY:
The Council reviewed the report of the Secretary as of November 30, 1980 which indicated that HMA membership totaled 922, the same as in November 1979.

REPORT OF THE TREASURER:
The October 1980 financial statement was reviewed in detail and filed subject to audit. Mr. Won recommended that Council establish a line item in the budget for administration of the HMA pension plan.

ACTION:
It was moved, seconded, and passed to establish a line item in the budget for administration of the HMA pension plan, with a budget of $3,000.

REPORTS OF COMMITTEES AND COMMISSIONS:

A. EMS: Dr. Stanley Saiki reported that the 1203 contract between the HMA and the SDOH is being reviewed by the Attorney General's office and will be forwarded to HMA in the near future for execution. The program is proceeding with implementation and a subcontract with the University of Hawaii is being negotiated for services to be rendered by the community colleges on Hawaii, Maui, and Kauai for training of first responders.

B. Interprofessional and Public Affairs

Membership Benefits—Dr. Philip McNamee reported that the committee has been studying various aspects of HMA membership including benefits to members, recruitment/retention programs, representation on governing boards, communication to members regarding activities, etc. The committee plans to develop a brief slide show for presentation to hospital medical staffs. Council was informed that medical students in Hawaii can join AMA directly without applying through the county medical society since they are classified as "special" members of HMA (and are not eligible to hold office). In an effort to increase medical student membership, the committee recommended that a proposed bylaws change be prepared to permit medical students to become full active members of HMA, with a recommendation to the counties to make the same bylaws change. Also recommended was the drafting of proposed bylaws amendments in two specific areas: (1) to permit Kona physicians and other appropriate sections of current county societies to form separate, independent component societies of HMA; and (2) to permit mandatory county/state association membership with *optional* AMA membership. It was further recommended that a special meeting of the HMA House of Delegates be convened in 1981, after appropriate circulation of the proposed bylaws amendments, for consideration of the proposed changes.

ACTION:
It was moved and seconded to direct the Bylaws Committee to draft a proposed bylaws amendment to permit medical students to become full active members of the HMA. The motion failed to pass.

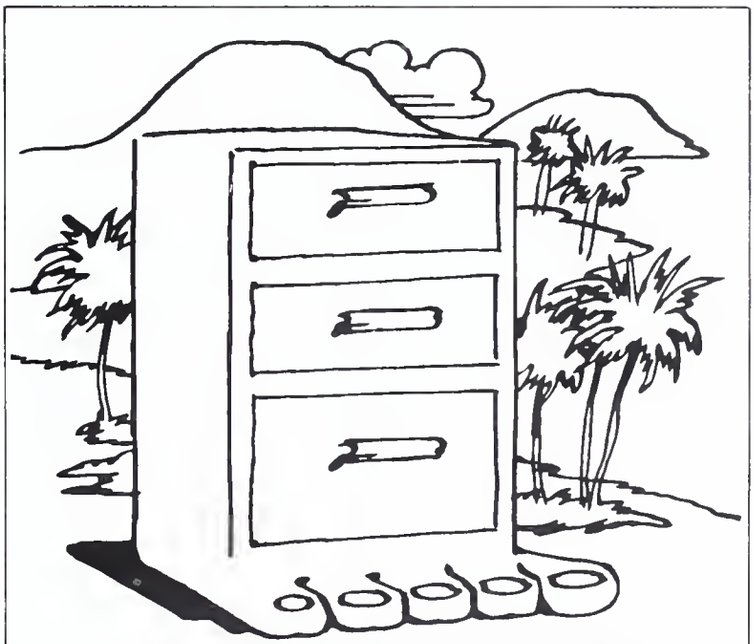
ACTION:
It was moved, seconded, and passed to direct the Bylaws Committee to draft a proposed bylaws amendment to permit Kona physicians and other appropriate sections of current county medical societies to form separate, independent component societies of HMA.

ACTION:
It was moved, seconded, and passed to direct the Bylaws Committee to draft a proposed bylaws amendment to permit mandatory county/state association membership with optional AMA membership. There were 5 opposing votes.

ACTION:
It was moved, seconded, and passed to convene a special meeting of the HMA House of Delegates in 1981 for consideration of the proposed bylaws amendments. There were 2 opposing votes.

Health Fair—Dr. McNamee reported that HMA has been invited to participate in a Statewide Health Fair being spearheaded by KHON-TV 2, the Hawaii Chapter of the American Red Cross, and the National Health Screening Council for Volunteer Organizations to be held in April 1981. The fair will be held at various sites throughout the State and will offer free basic health screening and education services, individualized health assessment interviews, and referrals to local health resources. The Public Affairs Committee recommended HMA participation in three areas: (1) endorsement, (2) establishment of screening test guidelines, and (3) provision of one physician to serve on the advisory committee in the screening of exhibits. Financial support was recommended. The committee also requested Council's opinion regarding the recipient of screening test results.

ACTION:
It was moved, seconded, and passed: (1) that HMA assist the Health Fair in developing screening test guidelines and (2) that HMA



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offer a physician as a consultant to the advisory committee. **Council recommended that screening test results be sent directly to the patient.**

125th Anniversary—Council was informed that the Public Affairs Committee is continuing to explore the concept of exclusively designed aloha apparel to commemorate HMA's 125th Anniversary. Since Council had felt the idea to be acceptable and the House of Delegates had approved a budget of $1,000 for the development of the design, the committee has entered into an agreement with Malia. Dr. McNamee pointed out that additional funds would eventually be required for production of the garments, once the design has been selected. A preliminary blueprint design was presented, and mixed reactions were expressed.

ACTION:

It was moved, seconded, and passed that the Public Affairs Committee, with Auxiliary input, decide on the design of the garments.

C. Health Service and Care: Dr. George Bolian reported that the Health Manpower Committee is presently conducting a survey on physician manpower. Dr. Bolian noted that the academic community has expressed some concern regarding the survey. An excellent response has been received to date. The committee recommended that Council adopt its proposed resolution which recommends the early creation of an Information Clearinghouse under HMA sponsorship to assist medical students, multi-specialty groups, etc. and foster effective communication regarding future job opportunities and the availability of qualified physicians.

ACTION:

It was moved, seconded, and passed to adopt the resolution re:Information Clearinghouse (as printed below).

RESOLUTION

RE: *INFORMATION CLEARINGHOUSE*

WHEREAS, many University of Hawaii medical students are interested in future job opportunities in Hawaii, and

WHEREAS, many physicians are also interested in future job opportunities in Hawaii, and

WHEREAS, multi-specialty groups, as well as individuals and smaller groups, are searching periodically for qualified new members, and

WHEREAS, communities throughout the State, especially on the Neighbor Islands, are searching periodically for qualified physicians, and

WHEREAS, provision of an information clearinghouse to foster effective communication among such parties would constitute a valuable public service, and

WHEREAS, provision of such a service would help to establish an early and helpful relationship between younger physicians and the Hawaii Medical Association, therefore, be it

RESOLVED, that the Health Manpower Committee recommends the early creation of such an information clearinghouse under sponsorship of the Hawaii Medical Association.

Dr. Douglas Bell reported that he and Mrs. Kendro represent HMA on the SHPDA Health Care Costs Task Force with representatives of hospitals, insurance companies, business, labor, government, etc. Presented to Council for perusal and comments was the section of the report which relates to physician cost containment strategies. The entire report will be transmitted to the State Legislature.

D. Medical Ethical Legal and Moral Concerns: Dr. Ann Catts reported that the committee has established a mechanism to provide consultative services to physicians and families. Informed consent will soon be on the committee's agenda, and Council members were invited to contribute suggestions for other areas of study. The Committee recommended that Council approve its proposed principles of resuscitation/non-resuscitation, which are designed to assist physicians in dealing with code/no code cases either at the time of admission to the hospital or during hospitalization.

ACTION:

It was moved, seconded, and passed to adopt the Principles of Resuscitation/Non-Resuscitation (as printed below).

PRINCIPLES OF RESUSCITATION/
NON-RESUSCITATION

1. A medical classification of the patient based on the expected degree of benefit from resuscitation should be determined by the attending physician. There should be periodic review of patients classified in Category II or III.
2. The patient, or, if the patient is incompetent, the family/agent should be adequately informed about the medical prognosis and the alternative responses to cessation of cardiopulmonary function.



3. The informed patient/family should make the decision regarding resuscitation and the decision should be recorded in the medical record. This decision may be changed by the patient/family and should be so recorded.
4. The decision not to resuscitate should in no way jeopardize the use of other support or treatment modalities, either required or reasonably expected to be given, in the care of the patient prior to cessation of cardiopulmonary function.
5. Economic considerations associated with continued care in cases deemed to be medically irreversible should be introduced during the course of informing the patient/family of the medical aspects.

E. AMA Delegate: Dr. Herbert Chinn highlighted the key issues discussed at the AMA Interim Meeting held during the first week of December in San Francisco. Some of the major issues considered by the AMA House of Delegates included PSROs, evaluation of foreign medical schools, active participation by women in organized medicine, state health planning, CT scanners, categorization of hospital emergency services, motorcycle helmets, Jail Program, physician suicides, podiatry, organ transplantation, etc.

F. Corporate Visitation Program: Dr. Neal Winn reported that HMA has scheduled its first corporate visit with the chief executive officers of Hawaii's top five employer firms for December 18. Discussion will focus on employers' health concerns and medical care costs.

G. Medical Malpractice Insurance: Mr. Jon Won reported that Argonaut Insurance Company has notified HMA that effective December 31, 1980, malpractice insurance premiums for physicians will be reduced 16%. With regard to the rate review hearing, Mr. Edmunds will meet with an actuarial firm to discuss type of work required and costs involved.

H. Internal Affairs: Dr. K. Y. Lum reported that the Arrangements Committee met to critique the activities held in conjunction with the 1980 Annual Meeting. Sports chairmen for 1981 have been appointed, and tentative dates selected for various special events. The site for the 1981 Annual Meeting will be the Hikai Hotel, from October 12-16, 1980.

I. Peer Review and Medical Education: On behalf of Dr. Schnack, Mr. Won reported that the Peer Review Committee will be working on its recommendations, as directed by Resolution No. 3 adopted by the House of Delegates, to formulate bylaws amendments for the establishment of specialty subcommittees under HMA's Peer Review Committee. Mr. Rice is currently researching the legal implications.

J. Public Health: Dr. James Lumeng reported that the Substance Abuse Committee met with representatives of the DIU and DEA. Issues discussed were entrapment, harassment, criminal violation, etc.

K. Medical Services: Dr. Thomas Cahill reported that a meeting of the committee chairmen and commissioner was held. Dr. Winn reported that he will refer the concept of the CHIP Plan to the commission for study. Further information on the plan will be requested from the Louisiana State Medical Society.

L. Legislation: Dr. Douglas Bell reported that the Committee held its first meeting to discuss the Association's focus for the upcoming legislative session. The committee plans to hold small cocktail sessions with key legislators. A suggestion was made that the committee consider preparing a list of bills and objectionable points so that physicians can write individual letters to their legislators.

REPORTS OF COUNTY SOCIETY PRESIDENTS:

A. Honolulu: Dr. Henry Fong reported that the Society will hold its next membership meeting on January 6 on medical malpractice alternatives. The program will feature speakers from PPAH, HAPI, and Argonaut. On behalf of the Board of Governors, it was recommended that for HMA scientific sessions, local faculty be limited to members of HMA. Dr. Fong reported that the Society will be trying to obtain regular listings of newly licensed physicians in Hawaii in an effort to recruit more members.

B. Maui: Dr. Andrew Don reported that Maui County held its annual Christmas party and installation of officers on December 6. The Society has received official notification regarding approval of the Society's subcontract with the CCPH for an oncology program to continue through July 1982. MCMS is actively pursuing its membership recruitment efforts.

C. Kauai: Dr. John Newman reported that the Society has elected its new officers for 1981—President, Mark Wentworth; President-elect, John Newman; Secretary-Treasurer, Paul Esaki.

D. Hawaii: Dr. Arch Wigle reported that Hawaii County is holding its annual Christmas Party and election of officers on December 12.

OTHER BUSINESS:

A. Big Island Visitation: Dr. Neal Winn reported on



his visitation with physicians in Kona. The Kona physicians have expressed their desire to form a separate component society in Kona in view of geographic distance from Hawaii County Medical Society's headquarters in Hilo.

B. Performance Evaluation of Executive Director: Dr. Neal Winn suggested that a periodic performance evaluation of the executive director be conducted.

ACTION:

It was moved, seconded, and passed that a performance/financial evaluation of the executive director be conducted annually by the Executive Committee.

C. Election: The Council elected Dr. John Keenan as HMA's representative on the Cancer Commission.

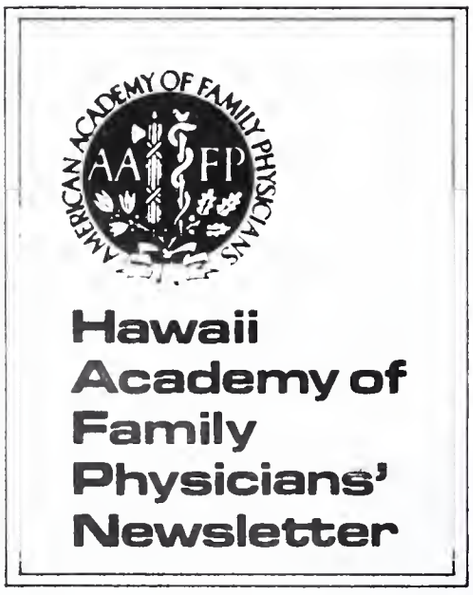
D. Negotiations Seminar: Mr. Won reported that HMA is proceeding with plans to hold a negotiations seminar on January 24-25, 1980. Speakers from the AMA Negotiations Department will conduct the seminar.

E. Auxiliary: Auxiliary President, Mrs. May Kim, brought the Council up to date on the activities of the county auxiliaries. County auxiliaries will be assisting in legislative activities. They have also been active in planning a Guest Day seminar, recruitment activities, and community service projects.

F. HAMPAC: Confirmed by Council were the following appointments to the HAMPAC Board of Directors for 1981: Richard Ando, Thomas Cahill, Albert Chun-Hoon, Raymond deHay, Richard Fardal, Bernard Fong, George Goto, Philip Hellreich, Leonard Howard, Roy Kuboyama, Allan Kunimoto, P. H. Liljestrand, Rodman Miller, Mrs. George Mills, William Moore, L. Q. Pang, Calvin Sia, E. Lee Simmons, George Takushi, Mrs. Jerome Tucker, A. L. Vasconcellos, Timothy Wee, Thomas Whelan, James Matayoshi (Hawaii), Pete Okumoto (Hawaii), Sakai Uehara (Maui), Patrick Aiu (Kauai), Katok Chuang (Kauai), Peter Kim (Kauai), Yonemichi Miyashiro (Kauai), Michael McCabe, and Ruben Mallari. HAMPAC Chairman for 1981 will be Dr. Leonard Howard.

ADJOURNMENT:

The meeting was adjourned at 9:50 p.m.



DON AND MARLIES FARRELL

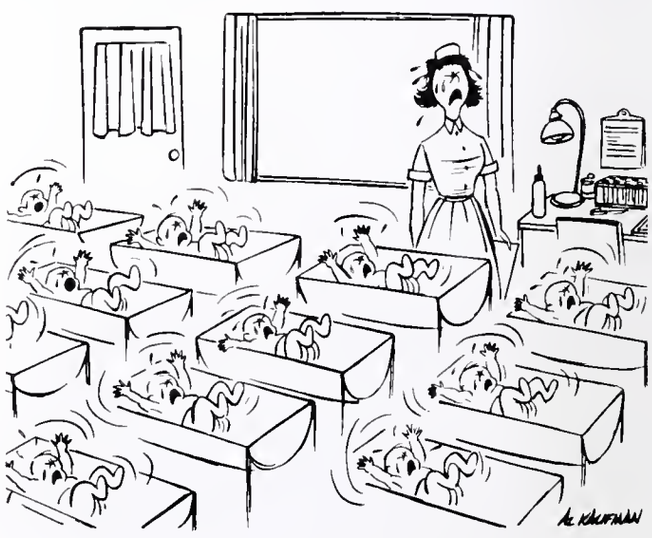
We welcome a **new member** this month: **Michael Sandys** has moved here from Florida and is practicing at Waianae Coast Comprehensive Health Center.

In other **news of members, Alan Chun** becomes an Active member, having completed his FP residency last summer . . . **Tom Cahill** was reappointed to the AAFP Mead Johnson Award Selection Committee . . . **John Rosemont,** a tripler FP resident, is a candidate for this year's award . . . December brought "blessed events" to at least two of our members: **Nate** and **Sandy Wong** became the adoptive parents of baby girl **Lisa** *Kanoe ula e aloha i na waa.* Hope her four-year-old brother **Kelii** can pronounce that name! . . . **Carmella** is the baby girl born to **Oscar** and **Marcia Sablan,** who already have three sons. **Marcia** is a third year resident at Kaiser . . . Other Kaiser residents make travel news: **Dave Gilmour** and his family are spending a month in Samoa, where Dave is serving a preceptorship and his wife **Sala** is enjoying time with her family, Samoa being her home . . . **Lloyd Kobayashi** just returned from a vacation in California with his family.

Last call for registrations for the **HAFP Seminar,** held on February 14, at the Ilikai in conjunction with the **Annual Meeting and Dinner.** The seminar has been approved for 6 hrs "P" credit by AAFP and features the following speakers and topics: **Drs. Don Farrell, Tom Cahill** and **Robert Worth** on "Computers in Clinical Medicine" . . . **Dr. Jeffrey Urman** on "Update Arthritis" . . . **Dr. Joseph Brown** on "Infectious Diarrhea" . . . **Dr. Patrick Walsh** on "Keikis are Breakable, Buckle Up Hawaii" . . . **Dr. Benjamin Tom** on "Honolulu Physicians Program IPA/HMO" . . . **Dr. Marc Coel** on "Nuclear Medicine and its Clinical Applications" . . . and **Dr. Steward Matsumoto** on "Ischemic Heart Disease, Sudden Death and Acute Myocardial Infarction." For registration information call **Marlies Farrell** at 235-3115. Invite your nonmember friends, the fee for both members and nonmembers is only $25.00. Residents pay $5.00 and medical students come free. Don't forget to mail in your registration for the **Annual Meeting and Dinner** also; remember, you may attend Annabelle's Disco without having to pay the cover charge that evening.

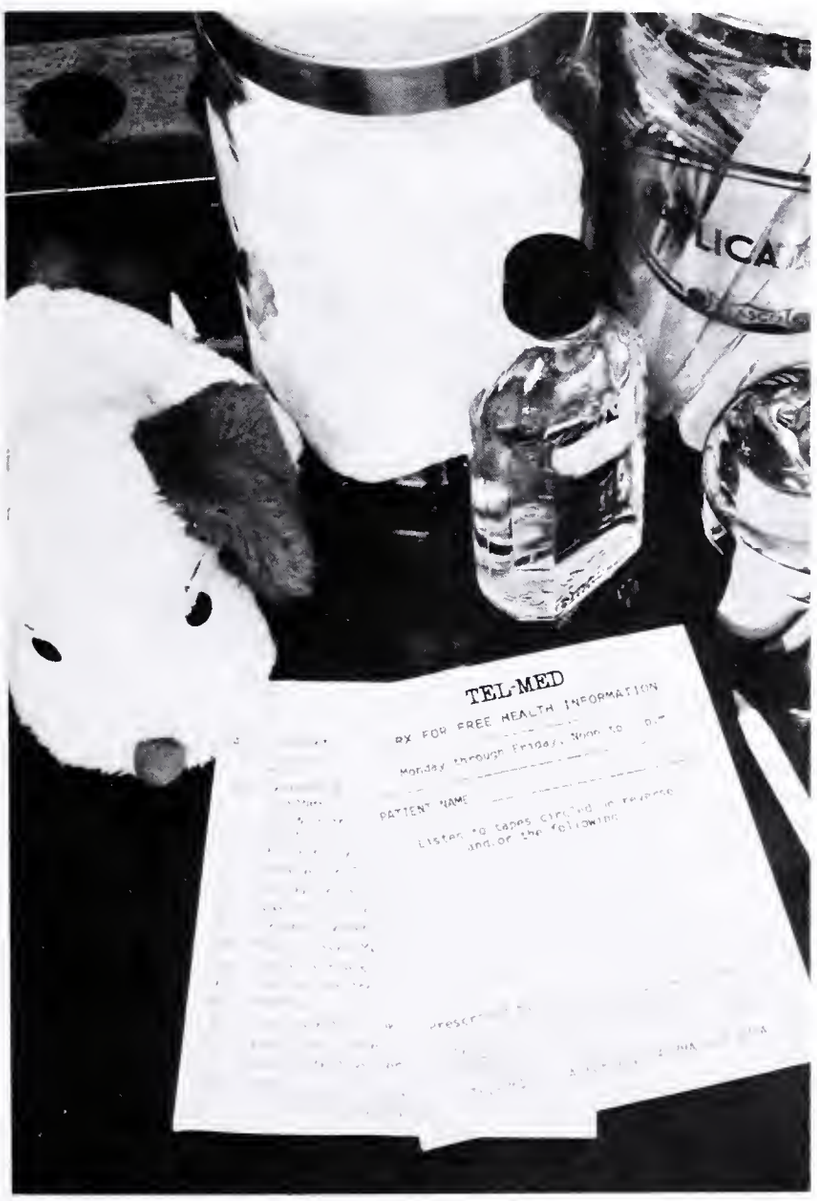
We are happy to welcome as our guests at the Annual Meeting AAFP President **Sam Nixon** and his lovely wife **Elizabeth.** During his visit Dr. Nixon will confer with **Dean Rogers** of U.H. Medical School and attend a luncheon hosted by the Tripler Family Practice Department. At the Annual Meeting he will install the newly elected officers and give brief remarks on national trends in family practice.

See you there!



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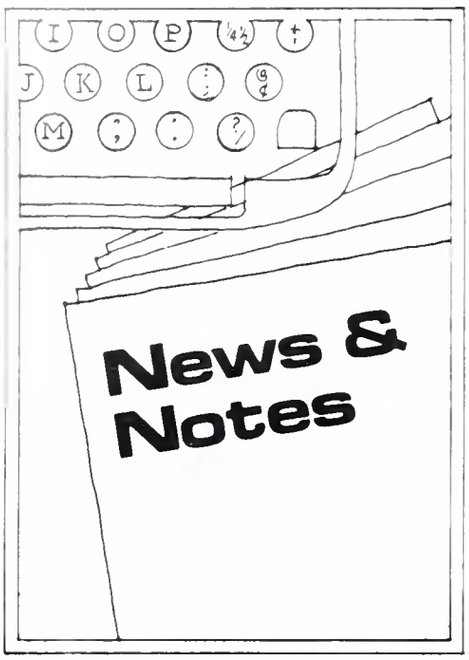
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HENRY N YOKOYAMA, M.D.

Hors De Combat

"Regardless, D. J. Strauss says her father, Dr. **R. C. Dusendschon,** medical director of Haw'n Tel, made a 12 layer pousse-cafe the other night. She said; 'He is not a professional bartender, but he has been making these beautiful and delicious drinks for years. I know—I used to drink his mistakes." (don chapman's column)

Jerome Estavillo, supervisor of the narcotics control section reported that Hawaii has a problem with physicians being intimidated by patients seeking a way to get drugs. The doctors situation is somewhat related to the flow of illicit drugs in the community. When there are more drug busts, the drug user is going to go elsewhere—where else but a legitimate source?"

A proposal to build a new medical office building near Castle Hospital has aroused the ire of a group of Kailua doctors who say the building would represent unfair competition. The Castle Professional Center would be financed by 29 physicians and two or three dentists with the blessing of Castle Hospital. Opposing the project are several doctors who own Kailua Professional Center and the nearly complete adjunct to the center in downtown Kailua.

Fearing prosecution by a state-federal drug enforcement agency, a number of Honolulu pharmacies (nine of Oahu's 10 Longs Drug Stores, all three Parkview GEM outlets and the Pay 'n Save stores) have stopped filling prescriptions for Quaalude. Sales of other prescription sedatives such as Seconal were being stopped by some pharmacies. The Hawaii Pharmaceutical Association feels that the INCS-DIU is trying to put pharmacists in the role of overruling physicians and enforcing drug-abuse laws. HMA president **Douglas Bell** feels that "the INCS-DIU is probably being more vigorous in its enforcement than they should be."

A report by the AMA's Council on Medical Service that says HMO's may provide a less expensive alternative to traditional medical care was not endorsed by the AMA delegates. The report shows that nine million Americans are enrolled in the nation's 233 HMO's whose number has expanded rapidly since the federal government began providing them grants and loans under a 1973 law. The contention is that the HMO members are seen oftener as outpatients and spend less time in hospitals than people under other plans. The federal Office of Health Maintenance Organizations has disbursed $112 million since the grants began. Delegates to the AMA convention spoke against the government subsidies and called them a subversion of the free market system of health care.

A $1.25 million out of court settlement of a malpractice case, the largest of its kind here, was reached in behalf of 8 year old Jo Anne Valdriz, who suffered brain damage at birth. The settlement cancels what was to be a six week trial over a $5.5 million lawsuit filed by the Valdriz family against the city, the Queen's Medical Center and two physicians. The City Council formally approved $800,000 as payment and raised the fee payment to its attorney Richard Quinn from $25,000 to $100,000.

The Carter administration is seeking to terminate medical school grants amounting to $44 million this year for the nation's 68,225 students. **Terence Rogers,** dean of the U of H Med School says elimination of the grants would be "mildly uncomfortable but not disastrous." The UH received $330,000 in capitation grants last year and $188,000 this year out of a total $11.5 million budget. "That amount of money missing is a cold draft, but it's not the end of the world for a budget that size. I'd say anyone sentient in the business could see it coming."

The UH Med School has graduated 380 physicians since becoming a four year college in 1973. The school is allowed to have an entering class of 67 students, virtually all from Hawaii and about a half dozen from Pacific islands. Terence Rogers says it is too early to tell whether the school is creating a surplus since more than half of the graduates have gone elsewhere for residencies and further training . . .

In September, the second successful case of "percutaneous tranluminal coronary angioplasty" or "balloon angioplasty" was performed in Hawaii by **John Cogan,** Honolulu Medical Group cardiologist with **Gerald Dorros,** assistant clinical professor at the Medical College of Wisconsin (who has 70 such operations under his belt). The procedure is palliative and could require repetition in a few years, and only 5 to 15% of patients have the appropriate block and anatomy, but 70 percent show positive results and require no by-pass surgery.

George Mills, chairman of the VCCC (Voluntary Cost Containment Committee) reported that hospital costs in Hawaii were 15.8 per cent higher in the second quarter this year than last, but revenues for the quarter went up only 10.18 per cent. The data reveal that the second quarter rise in expenses has not been passed on to the consumer . . .

Medical Economics reported that physician fees rose 13% the past year which is 1 point lower than the "all items" section of the CPI (Consumer Price Index) and 4 points below "All services."

The State Board of Nursing finally reversed its August decision prohibiting school health aides from administering prescribed medication to public school students (A practice which has been going on for years). The HGEA has maintained that if anything goes wrong, the nurses would be held liable since the nurses supervise the health aides. **Douglas Bell,** HMA president, and **Henry Yim** and **Jeanette Chang** (of the Honolulu Pediatrics Society and the Hawaii Chapter of the American Academy of Pediatrics) all felt that the practice should be continued and that the responsibility was that of the physicians and the parents. In the six weeks of school this fall when the health aides were prohibited from handling the medication, the work had to be done by school nurses, parents, brothers and sisters and the students . . .

Medicaid Fraud Unit Chief Stresses Need For Resources: Patrick Border, new chief of the unit said "the unit is picking up blatant cases and with enough time, I think we can pick up any kind of fraud." The State Medicaid Fraud Unit has a staff of 12 including two attorneys, three investigators and three auditors. It has successfully prosecuted nine doctors and pharmacists in two years and has four or five cases pending. The DSSH has its own unit with three investigators working on welfare fraud . . . Richard McDurmin, chief of this unit, says Medicaid fraud is a minor problem among recipients. The greater problem is welfare fraud with cases running up to $40,000 or $50,000 in overpayments.

Sportsmen

Jack Scaff, president of the Honolulu Marathon addressed the 36th Annual Meeting of the Western Conference of Prepaid Medical Service Plans at the Kauai Surf in Nov . . . "Athletes and physicians are immortality seekers . . ." Jack

maintains that one to six beers a day will increase the high density lipoproteins and "you can get even more of the stuff by establishing a regular exercise program . . . and the exercise has other benefits that beers lack." Jack says he's never seen a case of ulcers, diverticulitis, varicose veins that got worse, or any of the number of other physical complaints that require surgical procedures in marathon runners and those living active lives like marathoners . . ."

Kent Davenport, who handles the Honolulu Marathon invitations says, "We pay the airfare and room and board for the defending man and woman champions, but we don't have the money to bring people over here. Our total budget is only about $6,000." (It apparently takes $10,000 to bring someone like Bill Rodgers, the George Brett of running, down here.) Jack Scaff adds, "We have a hometown race with a world wide reputation and our philosophy doesn't lean toward changing that . . . Our philosophy is, if it works, don't fix it, and we have one of the most prestigious races in the world. We like our little race out here in the Pacific. It belongs to the people of the City and County of Honolulu and it's not for sale." (From Rick Woodson's sports column)

Psychiatrist **Douglas Schramel** describes "Marathonitis"—a disease, that is highly contagious and affects all ages. Esp. susceptible are those in professional and white collar occupations. "The basic pathology consists of an incessant almost constant urge for locomotion. In most cases this urge exists at the expense of intellectual activity. The etiology is thought to be an irritation of the blood-brain barrier which then results in a reversal of the pleasure-pain center in the mid brain."

HCMS Annual Tennis Tournament . . .

And lo and behold . . . It came to pass that the rains stopped and the tennis tournament started as scheduled at 11 a.m. that same Dec. 7 Sunday morning at HICC . . . Chairman **Ben Chang** had divided the players into A and B flights and the partners were chosen by drawing lots . . . It should be noted here that superman **Ron Peroff** ran the Honolulu Marathon in record time earlier that morning, went home to shower and showed up fresh and ready for tennis at 11 a.m. . . . The rules were as follows: Each team played a round robin series within its flight, each match consisting of 8 games, and the top two teams in each flight played off for the first two places . . . When all the sweating and swearing was over, A Flight winners were the winning duo of **Willie Tashima** and **Frank Lu.** In 2nd place were **Ben Chang** and **Henry Yim.** In 3rd place were **Worldster Lee** and **Wayne Lum;** in 4th, **Leabert Fernendez, Panu Limpisvasti;** in 5th, **Dennis Maehara** and **H. Yokoyama;** and in 6th, **Yutaka Yoshida** and **William Wong** . . .

B Flight winners were the team of **Y. Paik** and **Ernie Yim,** and in 2nd place, **Ron Peroff** and **Walter Watt.** In 3rd place was **Au** and **S. Wong;** in 4th, **E. Ho** and **R. Wong;** and in 5th, **Kubo** and **Reginald Ho** . . .

The best players did not necessarily win, but the name of the game was to have fun . . . and even those that played poorly agreed it was a fun tournament . . . Ben Chang deserves a well-earned pat on the back for a job well done . . .

HCMS Annual Golf Tournament

Unpleasant memories of playing 18 miserable holes in a drizzling rain last year lingered with us . . . And our intuition was nearly right . . . It poured rain two days and nights and until starting time . . . But miracle of miracles! Tournament chairman **Ed Kagihara's** fervent prayers were answered . . . The rains suddenly ceased and a drying wind made the course playable just in time . . .

A total of 97 participants including 26 women played in one of the most successful tournaments ever planned by Ed Kagihara and his hardworking cohorts, **Glenn Kokame, Henry Yim, Allan Young,** and **Tom Kobara** . . .

Low Gross winner was our legendary **Nobu Nakasone** who shot a gross 75 . . . Low Net was a happy **Clifford Chang** with a 79-18-61 . . . High Net was **Tom Oshiro** with 85 and High Gross was **John Houk** with 111 . . .

The scores were amazingly low . . . In A Flight (Handicaps 6-16), the results were as follows: 1st place **Ray Hatate,** net 64; 2nd and 3rd, **Don Maruyama** and **Gabe Ma** with net 66's; 4th to 6th, **Garth Morimoto, Hideo Oshiro** and **Eugene Matsuyama** with net 67's; 7th to 9th, **Richard Ho, Catalino Cachero,** and **Masaru Koike** with net 68's; 10th to 14th, **Richard Uehara, Herbert Nam, Russell Mezurashi, Harvey Takaki** and **Ed Kagihara** with net 69's; 15th to 21st, **Ernesto Orinion, William Morioka, Carl Kaizawa, Hal Yee, Ed Matsuoka, Kearny Chun Hoon** and **Coolidge Wakai** with net 70's . . .

The B Flight (17 to 36) winners were as follows: 1st, **Allan Young** with net 63; 2nd to 6th, **Tom Kobara, Ike Nadamoto, C.T. Hsin, John Edwards, Y.C. Lin** with net 65's; 7th was **Gordon Chang** with net 66; 8th was **Phil Kuo** with net 67; 9th and 10th were **Francis Oda, Steven Hirasuna** with net 68's; 11th to 13th, **George Takushi, Calvin Kam** and **Sid Lum** with net 69's; 15th to 17th, **Herbert Takaki, Richard Kimura, Alan Richardson,** with net 72's; 18th and 19th, **Sig Lim** and **Henry Fong,** with net 73's; 20th to 22nd, **Kenneth Kern, Dennis Murakami, James Oda** with net 74's . . .

MC Ed Kagihara aptly summed it up at the awards banquet later: "God, thank you . . . for no rain today!"



New Members



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Honolulu, Hawaii 96813

NEUROSURGERY



Scott Himeda, M.D.

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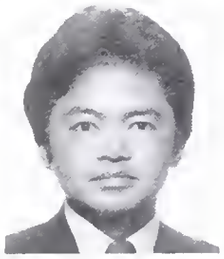
INTERNAL MEDICINE



Siang Yong Tan, M.D.

1697 Ala Moana Boulevard
Honolulu, Hawaii 96815

ENDOCRINOLOGY/
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Glenn A. Uto, M.D.

321 North Kuakini Street
Honolulu, Hawaii 96817

INTERNAL MEDICINE



Ernie M.S. Yim, M.D.

2228 Liliha Street
Honolulu, Hawaii 96817

PULMONARY DISEASE/
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Tax Relief

Why Invest In Real Estate

1980 was very satisfying in lots of ways for Bob. His practice grew by nearly 20 percent as did his income. Yet, he lost ground financially. And he will again in '81, unless he changes his system of investments.

Bob faces a problem common to successful professional people. He has a busy schedule with no spare time to devote to professional financial planning. He has an excellent income which places him in the 50 percent tax bracket; but because of the time constraints and lack of knowledge, he takes the easy route and puts extra money in low yielding instruments.

In 1981, Bob can turn this trend around, simply and without a lot of additional time and attention, through real estate investments. Here's how it would work.

As an example, let us say that Bob has $14,000 in an instrument that earns him 10 percent. This $1,400 earned is taxed at 50 percent, netting him $700.

Bob finds a satisfactory one-bedroom unit in a rental area priced at $70,000. He uses his low yielding instrument as a $14,000 down payment and takes out a mortgage for the balance. He can then rent out the condo at around $500 per month.

In his first year of ownership, Bob's rental income looks like this:

	YEAR 1 NET RENTAL INCOME (LOSS)	YEAR 1 CASH FLOW
Rental Income ($500/mo)	6,000	6,000
Maintenance & Utilities	(1,000)	(1,000)
Principal & Interest ($576/mo mortgage $56,000 @ 12% 30 yrs.)	(6,700)	(6,900)
Real Property Taxes	(300)	(300)
Depreciation (70,000 basis S.L. 20 yr. life)	(3,500)	—
Lease Rent	(325)	(325)
Taxable Income (loss)	(5,825)	
Tax Savings (assumes 50% federal tax bracket) 50% of $5,825		2,913
Net Cash In Flow		388

As we see above, the overall positive cash flow in the first year is $388, due to the "paper" loss generated by depreciation and the tax savings of paying $2,913 less to the IRS. This does not include the state income tax savings which will occur as well.

Of course, the depreciation does reduce Bob's cost basis, so at the beginning of the second year his rental unit has a tax basis of $66,500 ($70,000 - $3,500). Now he decides to sell it, rather than continue holding it for investment purposes.

Assuming he made a wise selection and his appreciation is 15 percent (not considering sales commission), Bob's rental is now worth $80,500. His gain will be the $80,500 sales price less $66,500 basis or $14,000.

Under current law, 60 percent will be totally excluded, with the remaining 40 percent taxable as ordinary income with his other income items. If Bob is within the 50 percent tax bracket, then the $5,600 gain ($14,000 less 60% exclusion) will result in only $2,800 additional taxes.

What does all this mean? Remember, Bob's after tax rate of return on the interest earned on his other instrument was 5 percent ($700 divided by $14,000 investment). Compare this to Bob's gain on the rental which results in an after tax rate of return of 80 percent ($11,200 gain divided by $14,000). By investing in the rental, Bob has almost doubled his money in one year.

For those who do invest, real estate can offer tax savings through depreciation as well as the available capital gains rules. With the continuing legislation in favor of home buyers and investors, the tax consequences of buying real estate should continue to be favorable.

The preceding is a compendium of tax information written especially for doctors by the Honolulu office of Peat, Marwick, Mitchell & Co. Please direct any inquiries to John Marks, 531-7286.

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Feelings vs.

Some people feel that I am misused and overused and that I'm prescribed too often and for too many kinds of problems.

The FACT is that approximately eight million people, or about 5 percent of the U.S. adult population, will use me during the current year. By contrast, the national health examination survey (1971-1975) found that 25 percent of the U.S. adult population experiences moderate to severe psychological distress. Additionally, studies of patient attitudes revealed that most patients have realistic views regarding the limitations of tranquilizers and a strong conservatism about their use, as evidenced by a general tendency to *de*crease intake over time. Finally, a six-year, large-scale, carefully conducted national survey showed that the great majority of physicians appropriately prescribe tranquilizers.

Some people feel that patients being treated with anxiolytic drugs are "weak," can't tolerate the anxieties of normal daily living, and should be able to resolve their problems on their own without the help of medication.

The FACT is that while most people can withstand normal, everyday anxieties, some people experience excessive and persistent levels of anxiety due to personal or clinical problems. An extensive national survey concluded

Facts

that Americans who do use tranquilizers have substantial justification as evidenced by their high levels of anxiety. It was further noted that antianxiety drugs are not usually prescribed for trivial, transient emotional problems.

Some people feel afraid of me because of the stories they've heard about my being harmful and having the potential to produce physical dependence.

The FACT is that there are thousands of references in the medical literature documenting my efficacy and safety. Extensive and painstakingly thorough studies of toxicological data conclude that I am one of the safest types of psychotropic drugs available. Moreover, I do not cause physical dependence if the recommended dosage and therapeutic regimen are followed under careful physician supervision. However, I can produce dependence if patients do not follow their physicians' directions and take me for prolonged periods, at dosages that exceed the therapeutic range, or take me in concert with other drugs, especially alcohol.

Many of the most knowledgable people feel that I became the No. 1 prescribed medication in America because no other tranquilizer has been proven more effective. Or safer.

The FACT is they are right.

For a brief summary of product information on Valium (diazepam/Roche) ℞, please see the following page. Valium is available as 2-mg, 5-mg and 10-mg scored tablets.

Valium® (IV)
diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy)
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults*: Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d., alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d., adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients*: 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children*: 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
Supplied: Valium® (diazepam/Roche) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available in trays of 10.

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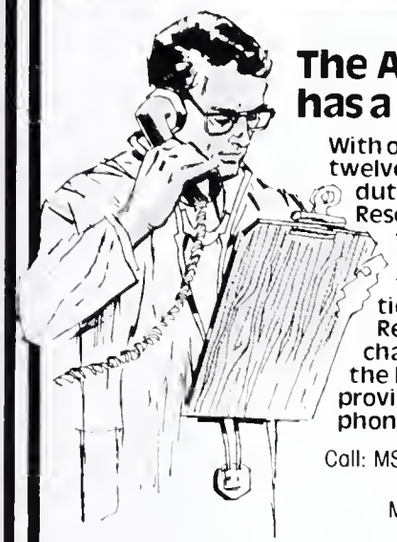
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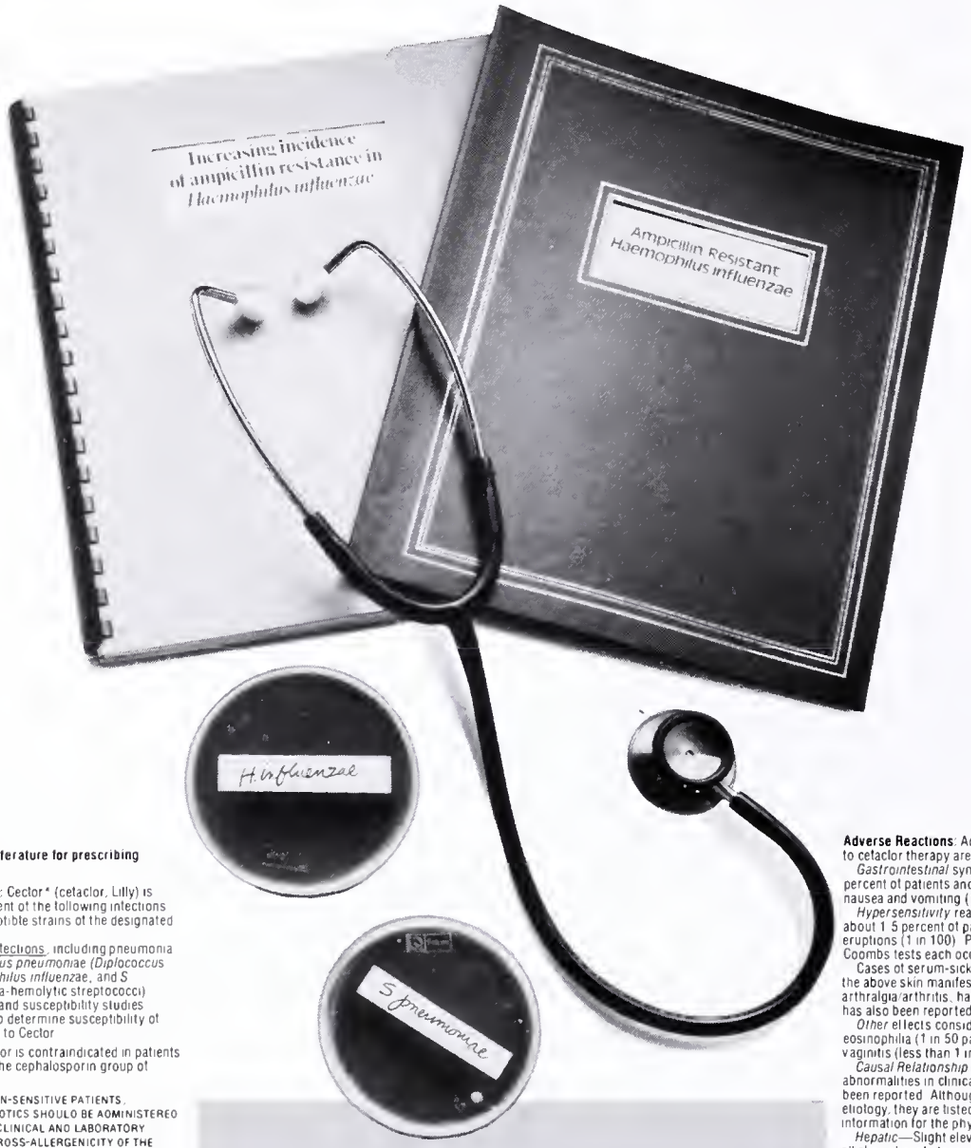


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An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

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Brief Summary
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Indications and Usage: Ceclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication. Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE)

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs

Precautions. If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e g , pressor amines, antihistamines, or corticosteroids

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Caretul observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, caretul clinical observation and laboratory studies should be made because sale dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly)

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below

Gastrointestinal symptoms occur in about 2 5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90)

Hypersensitivity reactions have been reported in about 1 5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients

Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported. Anaphylaxis has also been reported

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200)

[103080R]

* Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S pneumoniae* or *H influenzae* *

Note Ceclor* (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

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The Success of Hawaii's Medical Claims Conciliation Panel

TERRY T. SHINTANI, J.D. *and* H. WILLIAM GOEBERT, JR., M.D., J.D., *Honolulu*

Nothing ruins the doctor-patient relationship like a malpractice suit. Such has been the case since the time of Hammurabi (whose law required the loss of the doctor's eye if the patient's eye was lost) to the present. Hawaii's latest innovation to help resolve malpractice claims is the Medical Claims Conciliation Panel (MCCP or "the panel"). The MCCP, an efficient, timely, inexpensive, private way to help resolve malpractice claims, is a resounding success in Hawaii. Patients, lawyers, insurance companies, doctors, hospitals, and the judiciary are generally pleased with the results. The results have been analyzed in detail to determine how well the panel system is working and to explain the panel's function.

Since 1976, Hawaii law requires all medical tort claims (malpractice, negligence, and the like) to be heard before a panel called the Medical Claims Conciliation Panel, prior to the filing of a suit in a Hawaii state court. Today, before a physician or any health care provider can be sued for medical malpractice, the panel must hear the merits of the case, and render an advisory opinion. This opinion is non-binding, states the panel's findings of liability or non-liability, and recommends the amount of damages, if any. Neither the opinion nor any of the panel's proceedings can be used in a later court action. The panel system is a tool to help expedite a fair resolution of a claim without a costly public trial.

The Hawaii legislature established the MCCP as one of a number of measures passed in response to the medical malpractice crisis in Hawaii. The cost of medical malpractice insurance was rising precipitously. Insurance companies were refusing to sell malpractice insurance. Physicians and consumers were fearful of the disruption of medical care. The panel was created to screen out non-meritorious claims and to aid in settlement of meritorious claims. It was hoped the panel would help stabilize the cost of medical malpractice insurance without penalizing patients who might have legitimate claims.

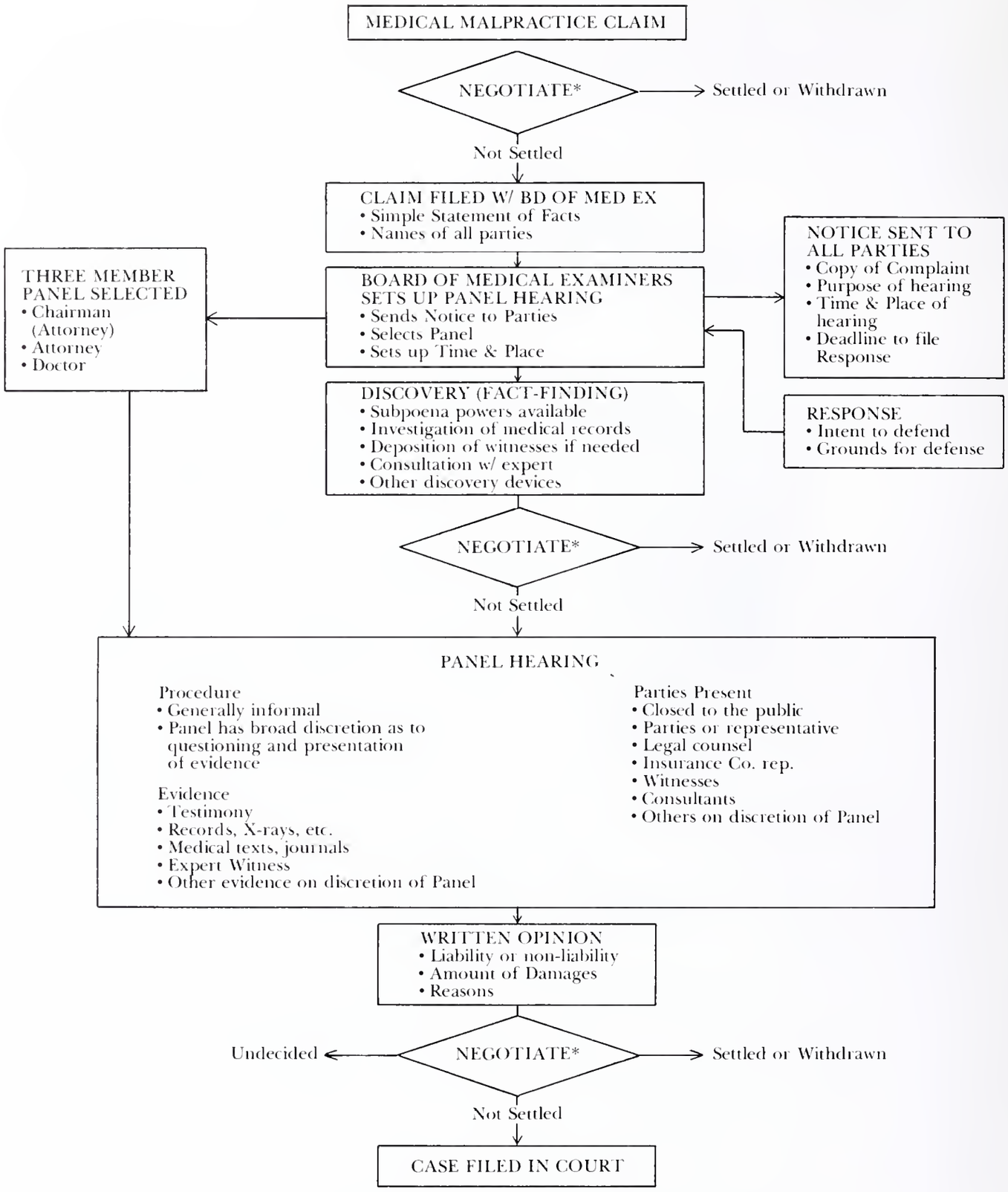
After roughly 4 years of existence, the panel has shown success. Medical malpractice insurance rates have stabilized. The panel is playing an important role in the settlement of a majority of malpractice cases. Fewer than 18% of all cases filed for a panel hearing have eventually gone to court. A large percentage of cases are settled for precisely the amount recommended by the panel.

Liability payments and defense costs appeared to be stable over the 2-year period since the panel was established, as compared to the 2-year period before its establishment. Paradoxically, while the claims are taking longer to be settled since the panel procedure was implemented, a majority of the doctors and lawyers who are familiar with the panel's operation feel it is definitely helpful in expediting settlement of malpractice suits. These conclusions are based on statistics collected by the authors on the panel's "track record," Argonaut Insurance Company's (Hawaii's major medical malpractice insurer) statistics, and opinion surveys of doctors and lawyers.

This article will describe the function of the panel, and its operation, and summarize results of a survey of physicians and lawyers regarding their opinions of the panel. Organization and procedures of the MCCP; general statictics regarding panel decisions, compared with the final disposition of the cases, and some data on the costs of malpractice defense before and after the establishment of the panel are presented.

Accepted for publication September, 1980.

FLOW CHART OF MALPRACTICE CLAIMS PROCEDURE



*Negotiations can take place at any point in the Hearing process. These points are where they most often occur.

Organization and Procedure

When a medical malpractice claim cannot be resolved amicably, the plaintiff (patient) must file a claim with the Board of Medical Examiners as required by law (Hawaii Revised Statutes Chapter 671). The chart graphically shows the steps which follow. (see chart)

After a malpractice claim is received by the Board of Medical Examiners, a panel hearing must be set up and panel members selected. The statute provides that each panel is to be composed of three members—a chairman appointed by the Chief Justice of the Hawaii Supreme Court, one attorney and one physician selected by the chairman.

The attorney is selected from a list of not less than 35 attorneys submitted annually by the Supreme Court of Hawaii, and the physician is selected from a list of not less than 35 physicians submitted annually by the Board of Medical Examiners. All members serve without pay.

In practice, the Executive Secretary of the Board of Medical Examiners chooses the mem-

bers of the panel from the lists and arranges the place and time for the meetings. The Executive Secretary selects physicians who have expertise for the type of case at hand. Usually strenuous objection by a party to any panel member is quickly handled by replacement with another person.

This informal panel selection procedure has much to do with the success of the panel system in Hawaii. The present scheme seems to minimize discontent with the panel before and during the hearing. As a result, the panel's decision has credibility with the parties and is more likely to be accepted.

In addition to selecting the panel members, the Board of Medical Examiners must send notice of the hearing, together with a copy of the complaint, by certified mail to all parties within 5 days of the receipt of the complaint. The notice states a deadline for the health care provider to file a response not more than 20 days after the notice is sent, and names a time and place where the meeting is to be held. The notice also describes the purpose of the meeting. The response which the health care provider must file is usually prepared by the health care provider's attorney, and generally informs the Board of Medical Examiners of the health care provider's intent to defend, and the grounds for such defense.

After a response is filed, the process of discovery or fact-finding takes place if a party or the panel so desires. The panel has subpoena powers, i.e. it can get a court order to compel the presentation of records or any documents, and the appearance and testimony of witnesses if necessary. Subpoena powers may be one of the most important features of the panel. Until the MCCP was established, a plaintiff (complainant) could not force a defendant to reveal certain records and evidence unless a claim was filed in court. Sometimes a complainant could not be sure that a legitimate malpractice claim existed, and would file a claim in court merely to get the court to compel the physician to reveal the medical records or other information. This was wasteful of the court's and the parties' time, and created expense simply to obtain a patient's medical records, sometimes for a "fishing expedition." The panel's own subpoena powers make such a wasteful procedure unnecessary and encourage immediate disclosure of all the necessary facts to help resolve the claim. (Note that Sec. 622-57 of the Hawaii Revised Statutes which became law at the same time as the MCP also provides for patient access to medical records.)

The hearing is informal, and the panel is given wide discretion as to how the hearing is to be conducted, with regard to methods of review, presentation of evidence, testimony of parties and witnesses, use of consulting experts, and the extensiveness of its written opinion. The hearing is closed and no persons other than the panel, the parties or their representatives and counsel, insurance representatives, witnesses, consultants, and others on permission of the panel may be present. The panel may conduct its own inquiry of parties, witnesses, or consultants with or without the presence of any or all the parties. The evidence received by the panel may be oral or documentary. Questioning of the parties, witnesses, or consultants is conducted by the panel, but the panel has the discretion to permit any counsel for a party to question other parties' witnesses or consultants.

In arriving at its decision, the panel has broad discretion in the evidence it may consider. In general, the panel considers statements or testimony of witnesses, hospital records, medical records, nurses' notes, x-rays, and other records kept in the usual course of the practice of the health care provider. The panel is not limited to these types of evidence. Other relevant evidence (including evidence that may not be admissible in court, such as medical articles and texts) may be heard as well. The panel may also, upon the application of any party or upon its own initiative, appoint a consultant to testify before the panel, to conduct any necessary examination of claimant or relevant evidentiary matter, and to report the findings.

After considering all the facts, the panel issues a non-binding written opinion. The opinion states the panel's findings as to whether the health care provider is liable for malpractice or not. The opinion also states an amount of damages if any. The panel has the discretion whether or not to include specific findings and reasons for its decisions. It can form its decisions without following strict courtroom requirements, such as the requirements of having a medical expert testify on the standard of care. Stating the reasons for the decisions helps the settlement process by giving the parties a better understanding of the results and helps to eliminate questions about the findings, questions that may motivate the claimant to ignore the panel's findings and take the case to court.

As stated above, this opinion is non-binding, i.e., any party has the option of accepting or rejecting the opinion. Claimant may reject a finding of "no liability" and file suit. Respondent may reject a finding of "liability" and refuse to pay any damages. Both parties may decide to agree on a settlement amount different from the amount recommended by the panel.

Moreover, the results of the panel hearing are not admissible in a subsequent trial. Some feel admitting the panel results in court or making the panel opinion binding on the parties would be desirable. The authors believe that it is important to the successful functioning of Hawaii's panel that its results not be admissible in court, and that its opinion be non-binding. Otherwise, the panel procedure or ruling of the court in which the panel results were used could

be opened to challenge on constitutional grounds. Such a challenge could be based on violation of the right to "due process" if evidence or procedures not allowed in court were used in the panel hearing, or it could be based on violation of a person's right to "a day in court." In order to avoid risk of later constitutional problems, both sides would have to approach the hearing as if it were a full-blown trial and would have to apply all the rules of evidence, in all their complexities. This would make the panel procedure cumbersome and time-consuming. These factors have caused the failure of panel systems in other states.

Statistics From The First 3 Years

The first three years of operation of the panel provide data to evaluate the panel's performance. A good indicator of the success of the panel is our comparison between the panel decisions and actual outcomes of the cases. Such a comparison shows how closely the outcomes of the cases follow the panel's decisions. It gives an indication of the influence the panel decision has in aiding settlement.

The authors had access to all the files of the MCCP and compiled data from all the cases for which decisions had been filed as of June 31, 1979, the end of its third fiscal year. The authors then contacted the parties' attorneys in order to compare the final outcomes of these cases with the panel decisions.

Of the 202 cases filed in the first 3 years, 139 have gone through the entire hearing process. Of these 139, 35 (25.2%) were eventually filed in court. When compared against the 202 total claims filed with the Board of Medical Examiners for a panel hearing, only 17.3% (35 of 202) eventually were filed in court. These figures cannot be considered final, because of 13 cases in which suit was still being contemplated but not yet filed, and 12 cases for which final disposition was unknown. Of the 139 cases decided by the panel, 79 (roughly 57%) were settled or dropped before reaching trial. Of the 202 total cases filed, 29 were disposed of without a hearing; thus, 108 of the 202 cases (53.5%) were disposed of before filing in court. Again, these figures cannot be considered final, because 34 cases were still pending hearing and other cases were of unknown disposition. Nevertheless, the record shows an impressive rate of screening malpractice cases. (See Table 1)

Of the 139 panel decisions, 98 (70.5%) found the health care provider not liable, and 41 (29.5%) found liability. The final outcomes of these cases after the panel rendered its decisions were distributed as follows.

Of the 98 cases in which no liability was found, 48 cases (49%) were dropped by the plaintiff. Of the 98 cases, 21 (21.4%) were pursued by the plaintiffs and filed in court; suit was contemplated in another 12 of the 98 cases (12.3%); 6 (6.1%) were settled out of court for various amounts, in spite of the panel's finding of no liability. The settlement amounts were relatively small, $5,000 being the largest. One case was held in abeyance, awaiting an outside medical consultant's review. The outcome of 10 of the 139 cases could not be found. (See Table 2)

TABLE 1—*Disposition of Cases Filed with MCCP in the First Three Years*

		% OF # OF CASES HEARD
Cases filed in the first year	66	
Cased filed in the second year	60	
Cases filed in the third year	76	
Total number of cases filed	202	
Total number of cases filed	202	
Withdrawn before hearing	-21	
Settled before hearing	- 7	
Dismissed for lack of jurisdiction	- 1	
Pending Hearing Date	-34	
Number of cases heard	139	
Cases settled or withdrawn	79	(56.9%)
Cased filed in court	35	(25.2%)
Suit being contemplated but not yet filed	13	(9.3%)
Cases of unknown disposition	12	(8.6%)
Total # of cases heard	139	(100.0%)
		% OF # OF CASES FILED
Cases settled, withdrawn, or dismissed	108	(53.5%)
Cases filed in court	35	(17.3%)
Suit being contemplated but not yet filed	13	(6.4%)
Cases of unknown disposition	12	(5.9%)
Cases pending	34	(16.9%)
Total # of cases filed		(100.0%)

TABLE 2—*Outcome of Cases in Which the Panel Found No Liability*

Claim dropped by plaintiff	48	(49.0%)
Filed in court pending trial	21	(21.4%)
Suit being contemplated but not yet filed	12	(12.3%)
Settled*	6	(6.1%)
Pending outside consultant	1	(1.0%)
Unknown outcome	10	(10.2%)
Total # of findings of No Liability	98	(100.0%)

*COMPARISON OF DECISION & SETTLEMENT

Key: Panel recommendation / Actual settlement

No liability / $3,500	No liability / $1,250
No liability / $5,000	No liability / $3,000
No liability / $2,000	No liability / $1,500

Of the 41 cases in which the panel found liability, 23 (56%) were subsequently settled out of court. In 16 of the 41 cases in which liability was found (39%), plaintiffs went on to file lawsuits in court. Of the claims filed in court, 2 were subsequently settled before trial, bringing the number of cases scheduled to go to court to 14 (34%). Some of these cases may have been filed in order to prevent the statute of limitations from

expiring, even though settlement of the case may have been imminent. Of the 25 cases which were settled, 19 were settled for amounts within 25% of the amount recommended by the panel. In fact, 15 of them settled for precisely the amount recommended.The final disposition of 2 cases was unknown. (See Tables 3 and 4)

TABLE 3—*Outcome of Cases in Which the Panel Found Liability*

Settled*	23	(56.1%)
Filed in court - settled out of court	2	(4.9%)
Filed in court - pending trial	14	(34.1%)
Unknown disposition	2	(4.9%)
Total # of findings of liability	41	(100.0%)

TABLE 4—*Comparison of Panel Recommendation and Actual Settlement Amount*

1.	$17,500 / $13,000	13.	$ 0 / $ 1,250
2.	$75,000 / $80,000	14.	$10,000 / $10,000
3.	$15,000 / $6,000	15.	$ 1,500 / $ 1,500
4.	$ 5,000 / 500	16.	$20,000 / $20,000
5.	$21,000 / $21,000	17.	$72,000 / $72,000
6.	$ 750 / $ 4,500	18.	$ 1,500 / $ 1,500
7.	$10,700 / $10,700	19.	$37,000 / $37,000
8.	$20,000 / $20,000	20.	$14,561 / $18,000
9.	$10,000 / $10,000	21.	$25,000 / $15,000
10.	$22,000 / $22,000	22.	$ 2,500 / $ 2,500
11.	$60,000 / $60,000	23.	$ 6,500 / $ 6,500
12.	$15,000 / $18,000	24.	$ 0 / $ 2,600
		25.	$42,000 / $42,000

Key: Panel recommendation / Actual Recommendation

The panel's effect on the settlement or withdrawal of claims cannot be determined with certainty. However, there was a similarity between the settlement amounts and the panel's recommended damage award in most of the settled cases. This strongly indicates that the panel had a direct influence on the settlement process. We suggest that the panel had a direct influence on most of the cases that were withdrawn as well.

The ultimate test of the success of the panel is in the courtroom. If the court decisions were consistently and substantially the same as panel decisions, there would be little incentive for claimants or respondents to continue the case beyond panel hearing. The panel would thus be fully serving its purpose of aiding in settlement or withdrawal of claims and be saving expensive and time-consuming trials. To date, only 2 cases have gone through the entire trial process. In one case, the court decision was consistent with the panel decision of no liability and in the other, the panel recommended $1,200 and the court awarded $3,900. While this is a positive indication that the panel is a good predictor of the outcome of a case, should it go to trial, much more data is necessary in order to withdraw any firm conclusions.

Cost of Defense Statistics

Comparison of panel decisions with the final outcome of malpractice cases seems to indicate that the panel is rendering fair decisions and aiding in the settlement of medical malpractice claims, but the question remains whether the panel, in fact, effects resolution of malpractice claims more quickly and more economically than the prior system. In order to answer this question, statistics gathered from Argonaut Insurance Company, the major malpractice insurer in Hawaii, were studied. Figures on the cost of malpractice defense, the amounts paid out in settlements, and the length of time taken for a claim to be processed and completed were gathered for the 2-year period prior to the creation of the panel. These figures were compared to similar figures taken from the 2-year period after the panel was established.

In the 2-year period prior to the establishment of the panel, 189 claims were opened and 138 were completed as of April, 1979, when that data was compiled. In the two-year period after the establishment of the panel, 145 claims were opened and 89 of those were completed as of September, 1980.

The average liability payment and average defense costs stayed essentially the same for the 2-year period after the establishment of the panel as compared to that of the 2-year period before the establishment of the panel. From the period "before" to the period "after," the average liability payment went from $5,466 to $5,166, and the average defense cost went from $2,207 to $2,657. (See Table 5)

A surprising finding was that the claims filed since the establishment of the panel took 6 months longer to complete than claims filed in the 2-year period before the establishment of the panel. Claims filed in the "before" period averaged 19 months from the day the claim was opened at Argonaut Insurance Co. to the day that Argonaut closed the claim. Claims filed in

the "after" period averaged nearly 25 months, an increase of nearly 6 months*. This result conflicts with the conclusion that the panel is helping to expedite the settlement of claims. (See Table 5) Yet the consensus seems to be that the panel is in fact aiding in the settlement process.

TABLE 5—*Defense and Liability Costs Before and After Establishment of MCCP*

	2 Years BEFORE	2 Years AFTER
Number of claims opened	189	145
Number of claims closed	138	89
Average Liability Payment	$ 5,466	$ 5,166
Highest Payment	$250,000	$200,000
Lowest Payment	$ 85	$ 110
Average Defense Cost	$ 2,207	$ 2,657
Highest Defense Cost	$ 21,351	$ 21,572
Lowest Defense Cost	$ 40	$ 50
Average time from opening to closing	19 months	25 months
Longest time from opening to closing	57 months	49 months

Opinion Surveys

Another measure of success of the panel is satisfaction of the parties. If the panel is to be successful, resolution of claims must be done in a credible manner and all parties must feel that a fair procedure has determined their fates. If they feel so, they would be more inclined to settle the claim in accordance with the panel's decision.

The authors conducted 23 attorney interviews and sent out 350 questionnaires to attorneys and physicians. The vast majority felt that the panel was helpful in resolving alleged malpractice cases and fair in its decisions. Of the 23 attorneys interviewed, 11 had appeared before the panel for claimants, 7 had appeared for defendants, 2 had been both panel member and had appeared in other cases for claimants, 1 had been both a panel member and a defense attorney, and 1 had been a panel chairman. Of the 305 questionnaires, 206 of them were sent to lawyers and 144 of them were sent to physicians or hospitals. The attorneys replying to the questionnaires numbered 95; these responses were tabulated along with the 23 personal interviews. A total of 104 doctors responded, 40 having been panel members, 58 defendants, and 6 both.

Perhaps the most important finding of the survey was that almost everyone agreed that the MCCP mandatory hearing is helpful in resolving alleged malpractice cases. In the survey, this question was put to all: "Do you feel that a mandatory pre-suit hearing is helpful in resolving malpractice complaints? _____yes _____no." Of those responding, 90% indicated "yes." (See Table 6) This result shows that doctors and lawyers, plaintiffs and defendants, as well as panel members, are overwhelmingly satisfied that the MCCP hearing is helpful in resolving malpractice claims.

It is also important that the participants feel the panel is fair, so a further question was posed to these same doctors and lawyers. The question was this: "Does the panel method seem to favor doctors or patients? Doctors _____ Patients _____ Neither _____ ." (See Table 7)

Roughly two thirds of all the doctors and lawyers who participated in the survey, 138 of 205 (67%), felt that the panel favored neither party. A total of 47 (23%) felt that it favored the doctor and 20 (10%) felt that it favored the patient. In other words, most of the doctors and lawyers responding to the questionnaire felt that the MCCP was fair and unbiased.

A question was posed as to whether they were satisfied with the structure of the panel. See Table 8 for the statistics on the answer to the question: "Is the panel makeup of two lawyers

*There is a fair amount of uncertainty in this figure because a claim may be opened by Argonaut long before it is actually filed with the MCCP and closed by Argonaut long after it is dropped by the plaintiff.

TABLE 6—*Is the Panel Helpful in Resolving Malpractice Complaints?*

	DOCTORS			LAWYERS	
	PANEL MEMBERS ONLY	DEFENDANTS ONLY	BOTH	MAIL	INTERVIEW
Yes	38	55	5	82	20
No	2	3	1	12	3
	Total yes	200	90%		
	Total no	21	10%		

TABLE 7—*Does the Panel Method Seem to Favor Doctors or Patients?*

	DOCTORS			LAWYERS	
	PANEL MEMBERS	DEFENDANTS	BOTH	MAIL	INTERVIEW
Favors doctor	5	5	0	33	4
Favors patient	5	9	1	4	1
Favors neither	26	38	5	51	18

	TOTALS	
Favors doctor	47	(22.9%)
Favors patient	20	(9.8%)
Favors neither	138	(67.3%)
	205	100.0%

TABLE 8—*Is the Panel Makeup Satisfactory?*

	DOCTORS			LAWYERS	
	PANEL MEMBERS	DEFENDANTS	BOTH	MAIL	INTERVIEW
Yes	27	24	6	78	21
No	7	16	6	9	1
Total	34	40	12	87	22

Other suggestions: 2 attorneys, 2 doctors; 1 attorney, 2 doctors; 3 attorneys, 2 doctors, 1 layperson.

and one doctor satisfactory? _____ yes _____ no . . . If no, suggest changes."

A large number of doctors and lawyers, 156 of 189 (87%) of those surveyed, were satisfied with the makeup of the panel. This is somewhat surprising, in light of the statistics that indicate 33% of them feel there is some bias in the panel system. Perhaps some of them felt the benefit of the panel outweighed the bias they perceived.

In isolated cases, attorneys complained that the time from the filing of a claim with the Board of Medical Examiners to its completion was unduly prolonged. Whatever the reason, all parties are harmed by any such delay. The statute of limitations is suspended by law when a claim is filed and the claim can become very stale. This problem is addressed to some extent by Act 88, Session Laws of Hawaii 1980, which provides a maximum suspension of the statute of limitations of 18 months from the time a claim is filed with the Board. This 18-month-limit provides some impetus for all parties and the panel to keep cases moving.

Conclusions

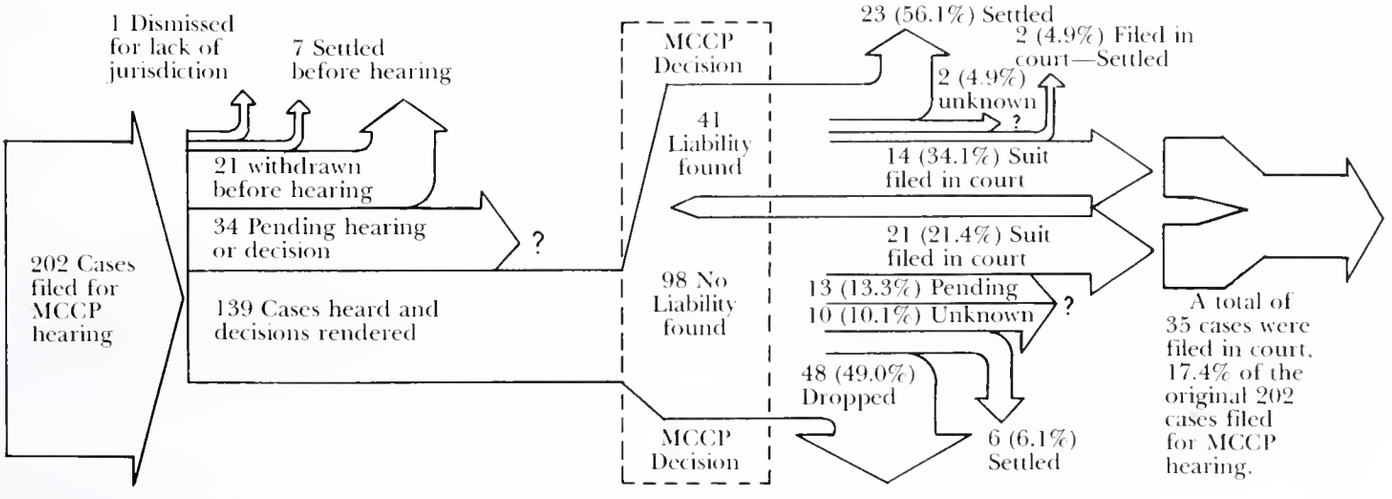
In our study of the first 3 years of its existence, we find the MCCP has compiled an excellent performance record. There is a close correlation between panel decisions and final outcomes of cases. This correlation indicates that the panel is accomplishing its intended purpose of aiding in the settlement of medical tort claims. Well over half of all claims which have been heard by the panel have been settled in accordance with the panel decision. Still others were settled without a hearing. Only about a fifth of the cases heard have been filed in court. In the 2 cases which have gone to court, the panel decision closely predicted the outcome. Data from Hawaii's major medical malpractice insurance company indicates that defense costs and liability payments have remained stable between the 2-year period before and the 2-year period after creation of the panel. Finally, and perhaps most important, a survey of doctors and lawyers, who have had contact with the panel, reveals a general feeling of satisfaction about the structure and performance of the panel. However, this does not mean that there is no room for improvement. Some felt that there was bias in the MCCP, and records indicate that settlement of malpractice claims has taken an average of 6 months longer since the panel was created.

Nevertheless, all the data and interviews taken as a whole indicate that the MCCP in Hawaii has performed admirably. It is undeniably playing an important part in improving Hawaii's means of resolving and disposing of medical malpractice claims. To be sure, it is a better system than that which existed in Hammurabi's day.

Acknowledgements

The authors would like to thank the following people who rendered invaluable assistance, and who should not be held accountable for any errors in data or conclusions herein: Patricia Putman, J.D., Richard S. Miller, J.D., L.L.M.; Bert Tomasu, J.D., Leo Rodby, and the staff of the Board of Medical Examiners; The staff of Argonaut Insurance Co.; Brian Miyagi of the Insurance Division of the Department of Regulatory Agencies; and Diane Nomura for her research assistance.

DISPOSITION OF CASES FILED WITH THE MEDICAL CLAIMS CONCILIATION PANEL (MCCP) 1976-79 (fiscal years)



An Abused Wife Before and After Filicide and Suicide by Her Husband

CLARENCE E. McDANAL, JR., M.D. *and* BOBBIE L. SIEGEL, *Honolulu*

We recently treated a 29-year-old abused woman whose abusing husband suicided after fatally poisoning their 9-year-old daughter. Since we followed this woman before and after this tragic event, we present her case report.

Case Report

This woman was raised in a home in which her father often beat her mother. When it came time for her to marry, she married a man who physically abused her and inhibited her from advancing in jobs or establishing a career. Because of his declining mental condition and his over-inhibiting behavior and demands, she went with her daughter to the Shelter for Abused Spouses and Children in Honolulu. After receiving much supportive care from various community agencies, other abused women, and the Shelter staff, she decided to cut all ties with her husband. This was most difficult, since her husband was very dependent, persistent, and demanding.

During this separation period, her husband asked to have a weekend visit with their daughter. At the time, this did not seem unreasonable, as there had been no recent history of physical child abuse, and the mother had no conscious suspicion of foul play. During that weekend, the father fatally poisoned his daughter and himself with cyanide. He also left additional cyanide, along with a note suggesting his wife suicide and join them. We were therefore concerned about her mental status and how she would respond to the note and this tragic event.

Before and during this crisis, this woman had pressured speech and tended to intellectualize her problems. Following the murder and suicide, she had a rested, relieved, more spontaneous expression, but continued to have pressured speech and intellectualization. We then gently confronted her regarding her feelings about the loss of her husband and daughter. She admitted feeling sad about the loss of her daughter and anger towards her husband. Her pressured speech and intellectualization decreased, and her affect and behavior became more realistic and appropriate for the situation.

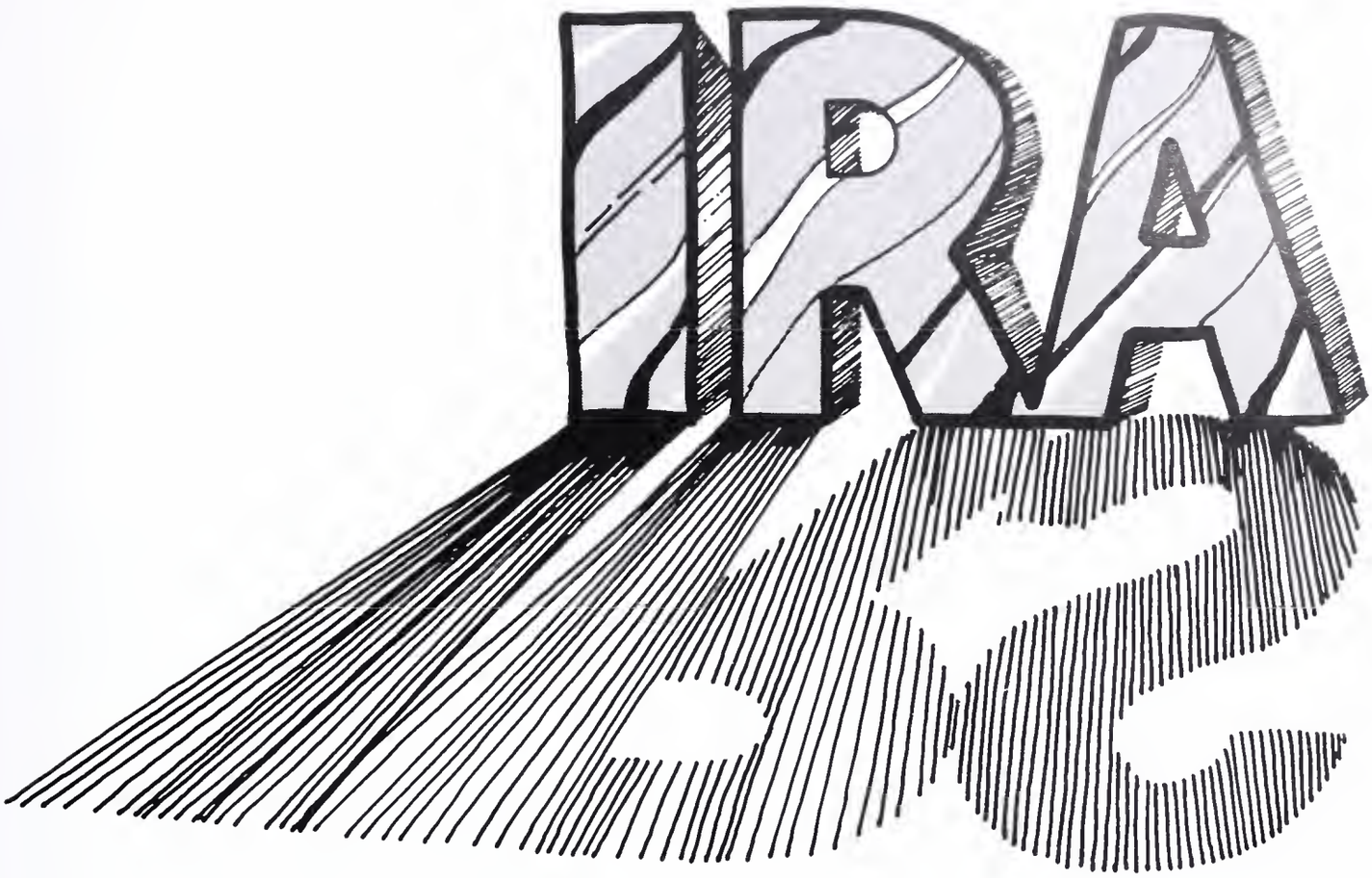
She went through a grieving process, including giving her daughter's clothes and possessions to charities and friends. She used the support of her church, friends, and Shelter staff. One year following the deaths, the woman was working, taking courses in college and was doing extremely well with no apparent emotional problems.

Discussion

Over a 4-year period from 1975-1979, more than 800 families were admitted to the Shelter. We counselled most of them. Among these families, we have heard of 4 abusing men who suicided or met violent deaths after their mates left them. We know of only one abused woman who was admitted to our Shelter and was later killed.

The factors which appeared to help this patient after the deaths of her daughter and husband were her realistic career goals, along with strong motivation to obtain them, and a very efficient, nurturing community support system, including school, church, and various community agencies. The Shelter staff was under the supervision of a psychiatrist (Clarence E. McDanal, Jr., M.D.) who directly assisted in the patient's care during her crisis.

Accepted for publication July, 1980.



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Editorials

Message From England

Two of Great Britain's fastest growing industries are health insurance and private hospitals. Enrollment in private medical insurance plans has increased 14% in the past six months, and in London nine large private hospitals (all owned or run by American firms) are now open or under construction.

All this effort aims at deficiencies in the "free" National Health Service, wherein 600,000 Britons are waitlisted for up to two years for beds in antiquated hospitals, reportedly riddled with deficits and overstaffed by bureaucrats. Meanwhile, 1.5 million Englishmen have recently chosen to buy private medical care, and there are now 122 private hospitals in England.

The British Labor Party has appropriately responded by demanding legislation to outlaw private practice, nationalize the pharmaceutical industry, and subsidize the NHS with up to $5 billion annually. Labor has accused the Conservative Government of neglecting the bankrupt NHS and encouraging the concept of private beds, hospitals, doctors and nurses. The Laborites lament that even trade unions are increasingly supporting the "flourishing" free-for-service concept, and they fear erosion of union support of the Party itself.

Meanwhile, the government hasn't a hope of increasing NHS funding, and views the development of the novel concept with some awe: "Imagine, a self-supporting medical care system financed through private insurance, at virtually no cost to the government! Why didn't we think of this before? Jove, the idea is positively smashing!"

Like our "noble experiment" of Prohibition, this 30 year British socialist experiment will collapse simply because it doesn't work. And the truths spring eternal: 1) When government offers "unlimited" free care, the cost will be infinite and the bureaucracy enormous. 2) No government has infinite funding, and the larger the program, the more unsatisfactory its performance. 3) Since mammoth government schemes will be insufficiently funded and unmanageable, the people will ultimately abandon them. You can't fool Mother Market!

JMC

Protection Increases Risks?

Several years ago the founders of the Physician's Protective Association of Hawaii (PPAH) expressed the unusual notion that having medical liability insurance increases one's *likelihood* of liability lawsuit. Just as medical insurance coverage tends to promote elective treatment, the theory goes, so liability insurance tends to promote elective lawsuits. In England malpractice litigation proves rare, and PPAH believes this occurs because physicians lack malpractice insurance (rather than vice-versa).

To prove its point PPAH, which provides legal defense for its members but pays no settlements or judgements, recently announced that after four years' experience involving over 600 physician-years of practice exposure, none of their members has yet appeared in court, or paid legal fees or judgements. The Association reports that, with strict "no settlement" rules and vigorous defense, plaintiffs' attorneys inevitably seem to lose interest, especially when they learn that the physician has no insurance.

Whether this impressive record results from improved physician selection and practice, or the effect of the Medical Claim Conciliation Panels, or truly signifies attorney disinterest in cases lacking easily accessible renumeration, remains uncertain. Dissimilarity of populations prevents meaningful statistical comparison of physicians choosing, or foregoing, liability insurance.

The PPAH concept that "the chief cause of malpractice suits is the mere existence of malpractice insurance" remains debatable, although refutation becomes more difficult every year. It's disheartening to think that the "protection" may increase the jeopardy; it's almost like fire insurance resulting in more fires.

JMC

The Chief Was Right

During my residency in 1966, our Chief said, of the advent of Medicare, "Physicians are right to oppose this political program. The costs will vastly exceed all projections, and the government will become insolvent supporting Medicare.

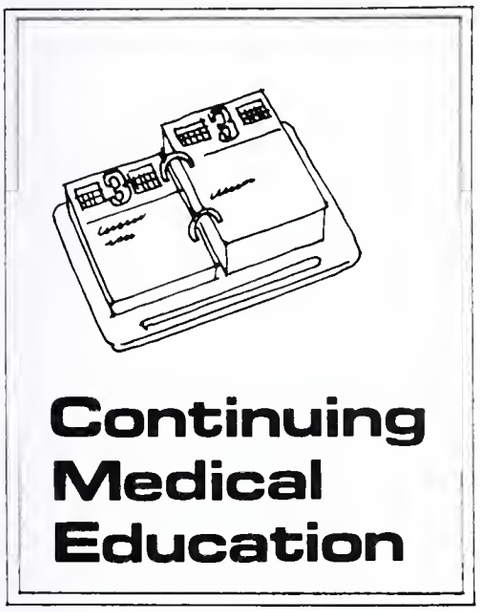
"Then, the social 'scientists' will seek a scapegoat, and blame physicians for runaway costs. The next step will be to impose controls on hospitals, then physicians, then on the entire system; these will further increase costs. When this approach fails, politicians will call for Nationalized Medicine. When *that* fails, as it surely will, politicians will blame you."

Item: "The primary force favoring greater intervention by government in the market for

medical services is the burden placed on budgetary resources of government in financing health programs created by the rising cost of medical care. This is especially true at the federal level where personal health care expenditures increased from three to ten percent of total federal expenditures between 1965 and 1973."

Reynolds: *Prospects for Regulation of the Health Care Sector in the 1980's.*

JMC



CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, First Thursday, 12:45 p.m. and Fourth Tues. 12:30 p.m. w/Maui Mem. Hsp. Held on Oahu at Am. Cancer Society main conf. room, 200 N. Vineyard, Honolulu.

John A. Burns School of Medicine

1. Dept of Medicine
 - A. Case Conferences, Second and Fourth Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 - B. Grand Rounds, First and Third Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 - C. Endocrinology Grand Rounds, Third Wednesdays, 5:30-6:30 p.m., Queens University Tower, Room 506.
 - D. Hematology Grand Rounds, Second and Fourth Mondays, 12:30-1:30 p.m., Queens University Tower, Room 721.
 - E. Cardiology Grand Rounds, First and Third Tuesdays, 5:30-6:30 p.m., Queens University Tower, Room 508.
 - F. Infectious Disease Grand Rounds, Second and Fourth Tuesdays, 5:00-6:00 p.m., Queens Nalani I Conference Room.
 - G. Dermatology Grand Rounds, Second Wednesday, 7:30-8:30 a.m. Queens, Queen Emma Clinic.
 - H. Pulmonary Grand Rounds, Second and Fourth Thursdays, 4:30-5:30 p.m., Queens Kamehameha Auditorium.
2. Division of Nuclear Medicine
 - A. Technical aspects of Nuclear Medicine, Second Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506, 1½ credits.
 - B. Rounds, Fourth Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506.
3. Dept. of Obstetrics and Gynecology
 - A. Grand Rounds, Wednesday 7:30-8:30 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
4. Division of Orthopaedics
 - A. Fracture Conference, Tuesdays, 5:00-6:00 p.m., Queens University Tower, Room 618.
 - B. Shriners Hospital Conference, Tuesdays, 7:15-9:15 a.m., Shriners Hospital.
5. Dept. of Pediatrics
 - A. Grand Rounds, Thursdays 8:00-9:00 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 - B. Pediatric Conference, Mondays 12:45-1:45 p.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 - C. Pediatric Infectious Disease Conference, Thursdays, 12:30-1:30 p.m., Kapiolani-Children's Medical Center, Third Floor Conference Room.
 - D. Neonatal Ground Rounds, Fridays, 8-9:00 a.m., Kapiolani-Children's Medical Center, Administrative Conference Room.
6. Dept. of Psychiatry
 - A. Grand Rounds, Fridays 8:00-9:30 a.m., Queens University Tower, Room 618.
7. Dept. of Surgery
 - A. Grand Rounds, First, Second and Third Saturdays, 7:30-9:00 a.m., rotating hospitals.
 - B. Statistical M and M, last Saturday, 7:30-9:00 a.m., rotating hospitals.
 - C. Journal Club, First and Third Tuesdays, 6:00-8:00 p.m., Queens University Tower, Room 620.
 - D. Medical-Surgical G.I. Rounds, Second Tuesday, 7:00-8:00 a.m., Queens University Tower, Room 506.
8. Depart of Family Practice
 - A. Conf., Wednesdays, 8-9:00 a.m. Kaiser 4th Floor Conf. Room.
 - B. Conf., Thursdays, 12-1:00 p.m. Kaiser 4th Floor Conf. Room.
9. Department of Physiology
 - A. Dept. Conf., Wednesday, 4:30-5:30 p.m. BioMed T-210.
10. University of Hawaii, John A. Burns School of Medicine Grand Rounds, Third Thursday, 4:30-6:00 p.m., Queen's University Tower, Room 618 or BioMed Building.
11. HI Oncology Group, one Monday a mnth., 12:30-1:30 p.m., The Cancer Center, 1236 Lauhala St., 4th Floor Conference Room.

Federation of Emergency Medicine-Maui

1. **Cardiology for the Emergency Physician**. Every Monday, 9-10:00 a.m.-Maui Memorial Hsp. Conf. Rm #1. (For spec. topics or further infor contact: Federation Office (808) 244-7629, or Dr. C. T. Mitchell, (808) 244-9056.
2. **Journal Club in Emerg. Medicine.** 2 hrs. Cat. 1. MMH Conf. Rm. #1. 9am-11 a.m.
 - 3/23/81 Annals of Em Med, 11/80; Abstracts in EM 12/80 - D. King
 - 4/20/81 Annals of Em Med, 12/80; Abstracts in EM 1/81 - S. Burkle
 - 5/25/81 Annals of Em Med, 1/81; Abstracts in EM 2/81 - P. McCallum
 - 6/22/81 Annals of Em Med, 2/81; Abstracts in EM 3/81 - J. Mills

Hawaii Thoracic Society

1. Pulmonary Med., Clinical case presentations & current research in pul. med. with U of H sinclair Chest

Club. Third or Fourth Wed., ea month, 7:30 p.m.-9:30 p.m. For further info contact: Rosemary Respicio, B.S.N. at (808) 537-5966.

Hickam Clinic

1. Clinical Correlation Conference, First Thursday, 11:00 a.m.
2. Didactic—our staff, Second Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, Third Thursday, 11:00 a.m.
4. Radiology Conference, Fourth Thursday, 11:00 a.m. (Contact Aurora Macapinlac, M.D., M.C., 449-5770)

Hilo Hospital

1. Orthopedic Conference, First Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, Second Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, Third Friday, 12:30-1:30 p.m.
5. C.P.C., Second Friday, 12:30-1:30 p.m.
6. Visiting Professor's Program

Kaiser Hospital

1. Medicine Grnd. Rnds. Every Tues. 8 a.m. Pac. Aud. 1 hr. Cat. I.
2. Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. I.
3. OB/Ped. Perinatal Mortality Conf. Last Tues. ea. mnth. 8:00 a.m. 1 hr. Cat. I.
4. Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. I.
5. Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. I.

(Contact CME Dept.-Kaiser for further information)

Kapiolani-Children's Medical Center

1. Pediatric Grnd. Rnds. Every Thursday, 8-9:00 a.m. Aud.
2. Pediatric Conf. Mondays, 12:45-1:45 p.m. 2nd Floor Aud.
3. Neonatal Grnd. Rnds., Fri. 8-9:00 a.m., Conf. Rm. B.
4. Pediatric Infectious Disease Conf., Thursdays, 12:30-1:30 p.m. 3rd Floor Conf. Rm.
5. Ob-Gyn Conf. Tues. 1-2:00 p.m. Aud.
 First—Didactic Presentation
 Second—Perinatal-Neonatal Topics
 Third—Obstetrics Topics
 Fourth—Gyn Topics
6. Tumor Brd.—Oncology Conf. First and Third Fri. 1-2:00 p.m., Aud.

Kuakini Medical Center

1. Department of Ophthalmology Meeting, First Tuesday, 12:30-2:00 p.m.
2. G. I. Conference, First Tuesday, 8:00-9:00 a.m.
3. Department of Medicine Meeting (Statistical), Fourth Tuesday, 1:00-2:00 p.m.
4. Nephrology Conference, Second Wednesday, 8:00-9:00 a.m.
5. Oncology Conference, Every Thursday, 7:30-8:30 a.m.
6. Pulmonary Conference, First Thursday, 1:00-2:00 p.m.
7. Surgical Conference, First Friday, 12:45-1:45 p.m.
8. Surgical Mortality & Morbidity Conf., Fourth Friday, 12:45-1:45 p.m.
9. Visiting Professors Programs
10. Department of Medicine Evening Meeting, Second Tuesday, 6:00-7:00 p.m.

Maui Memorial Hospital

1. Thurs. Conf. 7-8:00 a.m. Staff Dining Rm.
 1st—Dept. of Medicine
 2nd—Dept. of Surgery
 3rd—Dept. of OB/GYN
 4th—Dept. of Pediatrics
 5th—Elective
2. Tumor Brd. every Mon. 12:15-1:15 p.m.—Tumor Conf. Telephone Task Force—Third Tues. 12:15-1:15 p.m.
3. Dept. of Emergency Med., Third Mon., 7-8:00 a.m.
4. Diagnostic Radiology—Fourth Tues., 12-1:00 p.m.
5. SFH-UH Hematology Conf., Third Thursday, 12:30 p.m.Sullivan-4 Classroom.
6. SFH-UH Surgical Grand Rounds, First, Second, & Third Fridays, 7:30 a.m., Sullivan-4 Classroom.
7. Visiting Professor Programs (for further infor call CME office at St. Francis).

The Queen's Medical Center

1. ENT Conferences, First and Second Fridays, 7:30 a.m., Small Dining Room.
2. Medical Conferences, Every Friday, 8:00 a.m., Kam Auditorium.
3. Ob/Gyn Conferences, Second and Fourth Mondays, 1:00 p.m., Kam Auditorium.
4. Ophthalmology Conference, Fourth Tuesday, 5:00 p.m., Queen Emma Eye Clinic.
5. Orthopaedic Conferences, Every Wednesday, 7:00 a.m., Kam Auditorium.
6. Pathology Conferences, Every Wednesday, 7:30 a.m., Surgical Conference Room.
7. Pediatric Grand Rounds, Fourth Thursday, 12:30 p.m., Nalani I Conference Room.
8. Surgical Trauma Conference, Second Tuesday, 4:30 p.m., Kam Auditorium.

 Basic Science Lectures, Every Wednesday, 7:15 a.m., Queen's University Tower, Room 618.

St. Francis Hospital

1. SFH-UH Tumor Conf., Every Monday, 7:30 a.m. Sullivan-4 Classroom.
2. SFH-UH Nephrology Conf., First Monday, 1:00 p.m. Sullivan-4 Classroom.
3. SFH-UH Endocrine Conf., last Monday, 12:30 p.m. Sullivan-4 Classroom.
4. EENT Meeting, First Tuesday, 7:00 a.m., Sullivan-4 Classroom.
5. SFH-UH Hematology Conf., Third Thursday, 12:30 p.m. Sullivan-4 Classroom.
6. SFH-UH Surgical Grand Rounds, First, Second, & Third Fridays, 7:30 a.m., Sullivan-4 Classroom.
7. Visiting Professor Programs (for further infor call CME office at St. Francis).

Straub Clinic & Hospital

1. Straub Professional Seminar meets the Second Tuesday of each month, from 5:00-6:30 p.m. in the Credit Union Meeting Room (2nd Floor, Credit Union Bldg).
2. Surgical Mortality and Morbidity Conference meets every Fourth Thursday of each month, from 7:00-8:00 a.m. in the Doctors' Dining Room.
3. Cardiac Surgery Conference meets the Third Tuesday of each month, from 4:30-5:30 p.m. in the Doctors' Dining Room.
4. Department of Anesthesiology meets the Second Tuesday of each month from 7:00-8:00 p.m. in the Doctors' Dining Room.
5. Community Peripheral Vascular Conference meets the Fourth Thursday of each month from 5:00-6:30 p.m. in the Doctor's Dining Room.
6. Visiting Professor Program meets monthly from 7:00-8:00 a.m. in the Doctors' Dining Room.
7. Urology Inservice meets every other month on the Third Friday from 8:00-9:00 a.m. in the Doctors' Dining Room.
8. Neuropathology Clinical Correlation Conference meets the Third Thursday of each month from 7:30-8:30 a.m. in the Straub Morgue.
9. OB-GYN Pathology meets every Fourth Monday of each month from 12:30-1:30 p.m. in the Administration Conference Room (ACR).
10. Urologic Pathology meets every First Monday of each month from 8:00-9:00 a.m. in the Doctors' Dining Room.
11. Friday Noon Conference meets every Friday of each

month from 12:30-1:30 p.m. in the Doctors' Dining Room.

*Note: All conferences are subject to change. Monthly calendar will be available upon request.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—Second Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Miscellaneous

HMA Maternal and Perinatal Mortality Study Cmte. First Monday ea. month-7:00 p.m. 320 Ward Ave., S 200. Cat. I on hr. for hr. basis.

SPECIAL EVENTS

Mar. 2-6, 1981	Surgical Diagnosis & Therapy Phil Thorek Pstgrd. Courses, 850 Irving Park, Chicago, IL 60613. Hels-Kauai 20 hrs. Cat. I
Mar. 16-20, 1981	Sports Medicine Course-U of HI J. A. Burns Schl of Med. Box CE-CCECS, 2530 Dole St. Honolulu 96822. Cospons: AmAcadFam-Phys. Held: Princess Kaiulani Htl, Waikiki, Contact: Wayne Hamasaki, (808) 948-8244. 18 hrs. Cat. I.
Apr. 4, 12, 1981	Calif. Soc. of Anesthesiologists. Dr. Norman R. Catron, Exec. Dir., 100 S. Ellsworth Ave., San Mateo, CA 94401. Held: Kauai Surf, Kauai, HI.
Apr. 4, 11, 1981	Current Concepts in OB/BYN. U of Wash CME SC-50, Seattle 98195. Co-spons: Wash State Med. Assn. Held: Kona Surf, Kona, HI. 49 hrs. Cat. 1.
Apr. 4, 5, 1981	Fourth Annual Acute Care Seminar. Queen's Medical Center, 1301 Punchbowl St., Honolulu, 96813. 12 hrs. Cat. 1. Contact: CME Dept. Queen's (808) 547-4484.
Apr. 10, 17, 1981	Med. Imaging in Kauai. Am. Coll of Med Imaging, Box 27188, L.A., CA 90027. Held: Kauai Surf Htl., Kauai, HI. 24 hrs. Cat. 1.
Apr. 11, 18, 1981	Drug Therapy & Infectious Diseases. U of Wash., CME SC-50, Seattle, 98195. Held: Kona, HI. 49 hrs. Cat. I.
Apr. 11, 18, 1981	Office Management of Chronic Pain. U of Wash, CME SC-50, Seattle 98195. Co-spons: Wash State Med. Assn. Held: Wailea Beach Htl., Maui, HI. 49 hrs. Cat. I.
Apr. 12, 18, 1981	"Practical Aspects of Health Promotion; Skills for Disease Prevention in Communities." Spons: Harvard U Sch of Public Hlth, U of Kuopio, & International Cntr for Hlth Ed. Held: Kauai Beach Htl, Wailua, Kauai, 25 hrs. Cat. I. Contact: Robert Schmidt, M.D., Internat'l. Cntr for Hlth Ed., P. O. Box 3109, Lihue, Kauai HI 96766 (808) 245-2121.
Apr. 25, May 2, 1981	Diagnostic & Therapeutic Skills in Internal Med. U of So. Calif Sch of Med., 2025 Zonal Ave, L.A., CA. Held: Mauna Kea Beach Htl, Kamuela, HI. 5 days, 29 hrs. Cat. 1.
Apr. 25, May 2, 1981	Emergency Medicine, U of So. Calif Sch of Med. 2025 Zonal Ave., L.A., CA. Held: Royal Lahaina Resort, Maui, HI. 5 days, 29 hrs. Cat. 1.
Apr. 26, 1981	"Generic Drugs & Medical Care." Spons: Lederle Labs/Hawaii Medical Assoc. Held: 9 a.m.-4:30 p.m., Ilikai Htl., Honolulu. Contact: HMA Office, 320 Ward Ave., S 200, Honolulu, HI 96814 (808) 536-7702.
May 2, 9, 1981	Pathology. U of So. Calif Sch of Med., 2025 Zonal Ave, L.A., CA. Held: Mauna Kea Beach Hotel, Kamuela, HI. 5 days, 30 hrs. Cat. 1.
May 5, 10, 1981	Recent Advances in Surg: Emergency Surg Problems. White Mem Med Cntr. 1720 Brooklyn Ave, L.A., 90033. Cospons: Loma Linda U Sch of Med. Held: Ilikai Htl, Waikiki & Wailea Bch. Htl, Maui, HI. 24 hrs. Cat. I.
May 9, 16, 1981	Management of the Surg. Patient, Stanford U Sch of Med., Stanford 94305. Held: Mauna Kea Bch Htl, Kamuela, HI 96743. 6 days, 25 hrs. Cat. 1.
May 18, 21, 1981	Hawaii CME Sem. Loma Linda U Sch of Med, Anderson & Barton Rds., Loma Linda, CA. 92350. Held: Mauna Kea Bch Htl, Kamuela, HI. 4 days, 16 hrs. Cat. I.
May 18, 22, 1981	Med Oncology Review. Am Coll of Phys., 4200 Pine St. Philadelphia, PA 19104. Cospons: U of H Sch of Med. Held: Honolulu. Contact: CME, U of H, 1960 E-West Rd., Honolulu 96822, (808) 948-7457.
May 23, 30, 1981	Allergy & Immunology. U of Wash Cont Med Ed, SC-50, Seattle, Wash 98195. Cospons: Wash St. Med Assn. Held: Wailea Beach Htl, Maui, HI. 7 days, 49 Hrs. Cat. I.

OUT OF STATE

For information on any out-of-state programs or courses, refer to September 3, 1980 Supplement to JAMA or call the HMA Office.



Friday, January 9, 1981
HMA CONFERENCE ROOM

PRESENT:

Drs. Winn, Catts, Hindle, Bell, Chinn, Iaconetti, H. Fong, Bade, Chun-Hoon, Lumeng, Morgan, Shirasu, Bruce, Cahill, B. Fong, Simmons, Wigle, Fu, Newman, Mills, McNamee, Char, Goto, Hellreich, Chang, Dang, Mr. V. Thomas Rice, and Mrs. May Kim. HMA Staff present were: Messrs. Won, Jones, Leineweber, Ajifu; Mmes. Chang, Wong, and Morioka.

CALL TO ORDER:

The meeting was called to order by President Winn at 5:50 p.m.

REPORT OF THE SECRETARY:

Council reviewed the Report of the Secretary as of

December 31, 1980 which showed that HMA membership totaled 926, the same as in December 1979.

REPORT OF THE TREASURER:

The November 1980 financial statement was reviewed in detail and filed subject to audit. Council noted that income for 1980 is expected to fall short of projections in areas such as dues and Journal advertising.

ACTION:

It was moved, seconded, and passed to refer the Hawaii Medical Journal to the Bureau of Research and Planning to review the present and future status of the Journal.

ACTION:

It was moved, seconded, and passed that the Executive Committee conduct a cost-benefit analysis of HMA activities/projects for report back to Council.

The Finance Committee recommended that Council adopt a revised Building Fund Budget for 1981 subject to approval of the Building Committee. HMA's new building manager had modified the budget to reflect a revised tenant occupancy level and an expected increase in land lease rent.

ACTION:

It was moved, seconded, and passed to adopt the revised Building Fund Budget for 1981, subject to approval of the Building Committee.

Hawaii Medical Association—Building Fund 1981 Budget

	CURRENT YR. 1980 11 MONTHS	1980 ESTIMATED	1980 BUDGET	1981 BUDGET
INCOME				
Rent—Lease	134,395	135,526	145,893	178,210
Rent—Parking	1,835	1,240	13,116	14,760
Other—Interest	320	238	1,000	600
TOTAL INCOME	136,550	137,004	160,009	193,570
EXPENSES				
Owner's Expenses:				
Building Repair & Maintenance	2,305	-0-	5,000	12,200
Insurance	-0-	-0-	360	480
Electricity	1,700	1,700	1,844	2,340
Commission—Leasing	2,951	2,438	2,438	2,760
Professional & Legal	236	332	600	-0-
Lease Rent	36,190	39,480	39,480	54,300
Interest	59,345	64,964	64,943	61,200
Depreciation	31,550	34,418	32,896	34,080
Miscellaneous	9	18	120	600
TOTAL OWNERS EXPENSE	134,286	143,350	147,681	167,960
Common Area Expenses:				
Building Repair & Maintenance	12,349	16,008	8,316	9,840
Landscape Maintenance	7,842	8,060	8,400	8,400
Janitorial	10,679	11,592	12,072	12,960
Contract Repairs	26	-0-	1,596	600
Maintenance Supplies	477	526	4,200	4,800
Air Conditioning	9,851	11,674	9,504	10,200
Parking	8,394	11,216	13,800	12,000
Refuse	774	766	888	1,030
Pest Control	480	480	372	480
Electricity	29,377	28,468	29,327	48,840
Water	2,675	3,320	3,900	4,200
Management Fees	12,064	9,984	9,984	12,480
Insurance	3,459	3,774	3,360	3,360
General Excise Tax	5,570	6,472	7,267	8,970
Miscellaneous	44	48	-0-	240
TOTAL CAM EXPENSES	104,061	112,388	112,986	138,400
Recoverable Expenses:				
Real Property Tax	12,901	12,390	12,500	13,440
Assessment	3,955	7,910	4,000	-0-
TOTAL RECOVERABLE EXPENSE	16,856	20,300	16,500	13,440
Recoveries Income:				
CAM Recoveries	17,110	31,678	7,800	22,230
Real Property Tax	7,261	6,226	6,800	8,400
Assessment	121	132	2,800	-0-
TOTAL DIRECT RECOVERIES	24,492	38,036	17,400	30,630
TOTAL EXPENSES	230,711	238,002	259,767	289,170
NET INCOME—INCREASE (DECREASE)	(94,161)	(100,998)	(99,758)	(95,600)

In an effort to provide special services to members at economically advantageous levels and to generate income for HMA, the Committee recommended that Council authorize the expenditure of up to $1,000 for the establishment of a service corporation under HMA. Such services could include printing of stationery, fleet auto leasing, etc.

ACTION:

It was moved, seconded, and passed to authorize the expenditure of up to $1,000 to establish a service corporation.

Recommendations were also made: (1) that Council approve a request from Hawaii County to refund prorated 1980 dues to Dr. Keith Nesting who had resigned in August 1980; and (2) that Council approve an additional $100 above the TV-Radio Committee's budget of $5,200 to provide an operator for Tel-Med following weekly airings of "Your Body Your Mind," to gauge public response to the series as agreed with HMSA.

ACTION:

It was moved, seconded, and passed to refund Dr. Nesting's prorated dues for 1980.

ACTION:

It was moved, seconded, and passed to approve the additional budget request of $100 for Tel-Med.

REPORTS OF COMMITTEES AND COMMISSIONS:

A. Corporate Visitation Program: Dr. Winn reported that the first corporate visitation meeting was held on December 18 with the presidents or designated representatives of Hawaii's top five employer firms in attendance. The group felt that it would be desirable to have an ongoing business/medicine coalition with a view toward expansion of the committee at a later date. Business representatives expressed concern relative to physicians' handling of disability problems. To be explored is the possibility of an appeals mechanism for disability cases and alternative health insurance programs such as CHIP.

B. Medical Malpractice Insurance: Dr. Philip Hellreich requested permission to expend up to $3,000 for an actuarial study in working toward the rate review hearing. Council was advised of provisions of State law that would take effect if HMA files for a hearing.

ACTION:

It was moved, seconded, and passed to approve the expenditure of up to $3,000 for an actuarial study in working toward the rate review hearing.

C. Internal Affairs: Presented for Council's information were proposed bylaws amendments requested by Council at its 12/12/80 meeting which would provide for: (1) separate, independent component societies within a single county, and (2) optional AMA membership. Staff was requested to check with the AMA's Legal Department to investigate the usage of the term "component" society. Prior to the Special House of Delegates meeting, it is anticipated that organizational meetings will be held to develop pro and con position papers on the unit membership rule issue. The Bylaws Committee requested Council's indulgence in deferring action on 1980 Resolution No. 3 re, Specialty Subcommittees under HMA Peer Review Committee pending legal clarification.

D. Health Service and Care: Dr. Donald Char reported that the Community Health Care Committee met to review the annual Health Services and Facilities Plan (previously titled State Health Plan). SHPDA will hold public hearings commencing next week. The Department of Health has developed a State Functional Health Plan for incorporation in the State General Plan. The Functional Plan addresses health program planning for the State over the next ten years. In the manpower area, a joint subcommittee with HMA and Medical School representatives will develop a statement on the UH Medical School.

E. Interprofessional and Public Affairs: Dr. Philip McNamee reported that Communications Supervisor, Ceci Young, has resigned her position with HMA as of January 1. Mr. Jon Won announced that Mrs. Becky Kendro has been promoted to Executive Assistant for Community Affairs, and her duties will include the communications/public relations area. For HMA's 125th anniversary, the Public Affairs Committee is exploring the possibility of a commemorative issue of the Journal and exclusively designed aloha apparel. Council suggested that HMA approach the Governor on the possibility of proclaiming a special anniversary week. In the membership area, the President reported on his recent visit with Kaiser representatives.

F. Medical Services: Dr. Thomas Cahill reported that the Department of Labor has issued a new Workers Compensation Medical Fee Schedule effective January 1, 1981. The schedule appears to incorporate the terminology of the RVS. A recommendation was made regarding the usage of CPT codes after January 1982.

ACTION:

It was moved, seconded, and passed that HMA go on record as strongly encouraging HMA members' usage of the CPT (Current Procedural Terminology) codes exclusively after January 1982.

G. Legislation: Dr. George Goto reported that the State Legislature will open on January 21. Physicians were encouraged to attend the opening day festivities.

H. EMS: Dr. William Dang reported that the federal contract for neighbor island EMS training is still pending. On behalf of the EMS Board, Dr. Dang recommended that Council support the position of the EMS Board regarding a trauma center. The EMS Executive Board feels that there should be no trauma center designated in the State at present because there are no hospitals which can fully qualify as such.

ACTION:

It was moved, seconded, and passed to support the stand of the EMS Executive Board.

REPORTS OF COUNTY SOCIETY PRESIDENTS:

A. Honolulu: Dr. Henry Fong reported that the HCMS held an excellent program in January on Medical Malpractice Alternatives. The Society's next meeting, "Financial Planning for the 80's" will be held on February 3 at the Ala Moana Hotel. With regard to HMA's anticipated survey on the unit membership rule, the HCMS Board recommended

that survey respondents be asked to list under what conditions they would join HMA, that the survey be non-anonymous, and that there be a modality for follow up on non-respondents.

B. *Maui:* Councilor Dr. Denis Fu reported that Maui County held its annual meeting and installation of new officers in December. The Society's upcoming meeting on February 4 will feature Xelan representatives. Recruitment efforts are continuing.

C. *Hawaii:* Dr. Ernest Bade reported that Hawaii County held its annual meeting on December 12. Elected as officers for 1981 were: Ernest Bade, President; Manas Ghosh, Vice President; Robert Irvine, Secretary; and Ben Hur, Treasurer.

The Council congratulated the new county society presidents.

OTHER BUSINESS:

A. *Auxiliary:* Mrs. May Kim reported that the HCMS Auxiliary will hold its annual guest day program, "What's Right with the World: A Wellness seminar," on February 21, with a guest speaker from the mainland. The Auxiliary will be working closely with the HMA Legislative Committee in sending out congratulatory letters, preparing opening day gifts, and hosting cocktail receptions for legislators. The Auxiliary expressed a desire to participate on any HMA committees desiring Auxiliary input.

B. *Negotiations Seminar:* Mr. Jon Won reported that 28 individuals are registered in the upcoming seminar on January 24-25.

ADJOURNMENT:

The meeting was adjourned at 8:45 p.m.

Hawaii Academy of Family Physicians' Newsletter

DON AND MARLIES FARRELL

Aloha to two **new members** this month: **Bernard K. Chung,** a transfer from California where he completed a family practice residency, becomes an Active member, as does **Robert Conrad** from Colorado, now practicing in Waimea, Kauai . . . **Craig Kadooka** changes his membership to Affiliate. Because of the phasing out of the UH-Kaiser FP residency program he moved to a residency in internal medicine but wishes to remain a member of our chapter.

In other **news of members,** we mourn the loss of **P.S. Irwin,** of whose death in August of 1980 we were only recently informed. Dr. Irwin was a charter member of our chapter and was honored in 1974 at our annual meeting for having been in practice for 50 years . . . **Mona Bomgaars** was recently appointed chief of the Communicable Disease Section of the State Health Dept. by Commissioner **George Yuen.** Mona previously served as Associated Professor of family practice at the UH School of Medicine. In this role she travelled throughout many of the third world countries, developing health care services . . . **Wilmot W. Boone** returns from Wake Island in March and is interested in a position "anywhere in the Pacific Basin" . . . Congratulations to **Tom Cahill** on becoming President Elect of HCMS.

Because of scheduling conflicts our Executive Council will now meet every second Thursday at Queen's Medical Center in the Harkness Pavilion. We are grateful to Honolulu Medical Group for providing us with a comfortable meeting room for the past two years.

At the last Council meeting Tom Cahill reported that both HMA and HCMS strongly encourage use of the new CPT (current procedural terminology) codes after January 1982 for billing purposes. CPT coding has been accepted nationally by Medicare, Medicaid and Champus. Copies are available thru HMA.

We have received news that the Michigan chapter has won its Fee Discrimination lawsuit against HHS after 4 long years. HHS along with Blue Cross, Blue Shield had been reimbursing specialists at a higher rate than FPs. Michigan claimed that this was unfair and the court agreed. Hurrah for our side, our chapter's contribution to their legal fund was certainly well spent!

Headquarters reports the passing of a milestone: it has enrolled our 50,000th member. AAHP is the second largest medical organization, exceeded only by AMA and the largest specialty society. Unprecedented growth has marked the Academy in the last several years as young doctors have entered the specialty in large numbers.

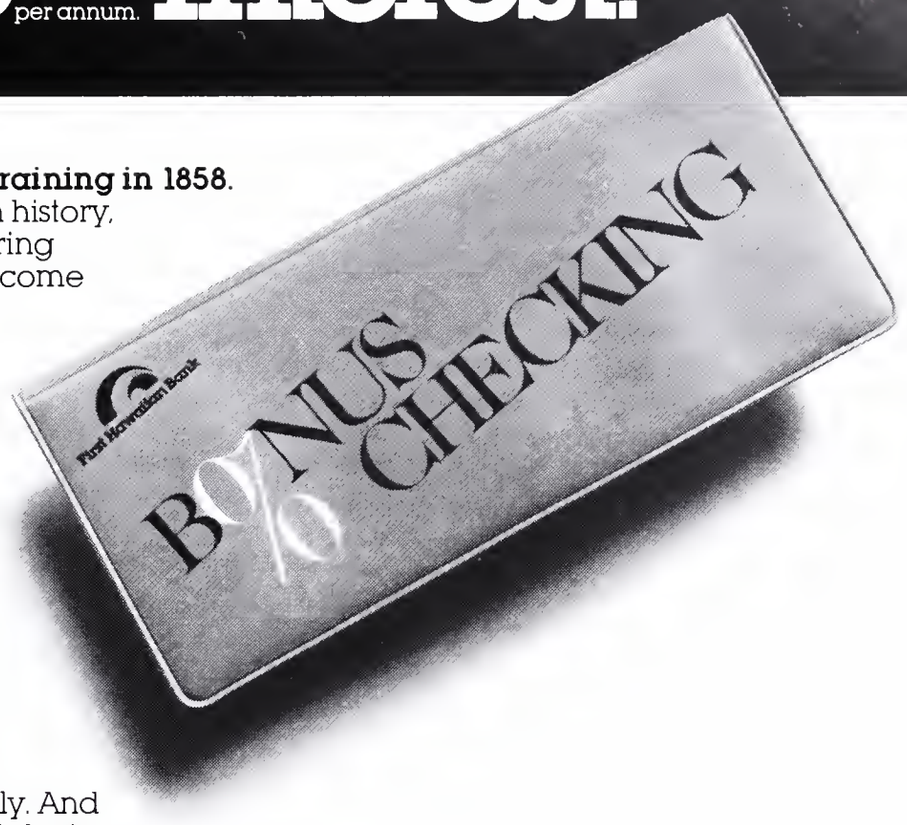
Received from **Jim Tsuji:** The Hawaii Asthma Camp will be held March 27 thru 29 at Camp Kaiulani in Kailua for asthmatic children, age 8-12, who are on daily medication. Call Art Yorita at 537-6954 for info.

Lots of **CME hours** are being offered on all islands during March and April, check page 81 of the Jan. "American Family Physician."



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In Memoriam



Hastings Howland Walker, M.D., F.A.C.P.
1899-1981

Hastings Walker was born May 24, 1899, in Hilo, Hawaii, son of Sidney G. and Katherine Howland Walker. He was educated at Phillips Exeter and Dartmouth College, and received his M.D. from Columbia University College of Physicians and Surgeons in 1923. After an internship in Orange, New Jersey, he served 6 years at Leahi Hospital as a resident physician.

He was married to Maude Atkisson of Coalinga, California on April 4, 1925, and after his residency terminated, he went abroad for study in Vienna and at the National Heart University in London. He returned to Honolulu late in 1930 to become Director of Leahi Hospital, a post he was to hold for the next 34 years, retiring from it with honor on July 14, 1964.

From 1949 to 1964 he was consultant in pulmonary diseases to Tripler Army Medical Center, and was made emeritus consultant there in 1964. He was Area Office consultant in tuberculosis to the Veterans Administration in San Francisco from 1948 to 1965, and to the regional office in Honolulu from 1951 to 1964. He was consultant in chest diseases to Shriner's Hospital for Crippled Children, The Queen's Hospital, and the Territorial Hospital. He was a charter diplomate of the American Board of Internal Medicine (subspecialty, tuberculosis).

He was a Fellow of the American College of Chest Physicians, and a regent of the College from 1947 to 1962, when he was made an honorary regent; he was president of the Hawaii chapter in 1953. He was a Fellow of the American College of Physicians, and Governor for Hawaii from 1958 to 1964. He was elected councillor-at-large of the American Thoracic Society for a 3-year term beginning in 1957. He served for years on the chronic illness committee and the advisory committee to the Bureau of Tuberculosis, of the Hawaii Medical Association, and was a member of the American Medical Association throughout the years when membership was optional. He was a member of the American Association for the Advancement of Science, the Hawaiian Academy of Science, the Hospital Association of Hawaii (president, 1953), the advisory committee to the Pacific Institute of Health, University of Hawaii; the citizens liaison committee of the East-West Center, the Tuberculosis and Health Association of Hawaii (Director at Large, 1961-1964, and first honorary member, 1964); first president of the Oahu Tuberculosis and Health Association (1931-1935), board member 1952-1954, and first honorary life member, 1955; and he served on a dozen major standing committees of the Hawaii Medical Association between 1935 and 1963. He served as consultant in tuberculosis on two occasions, to the governments of Panama and American Samoa.

He had some 15 papers published, or given before medical societies, between 1925 and 1962; the last was an article establishing the etiology of an endemic skin disorder in Hawaii as *Mycobacterium balnei* (now *M. marinum*), though the disorder had previously been reported as tuberculosis verrucosa cutis.

In addition to all this, Dr. Walker was a most scholarly physician, with special interest in medical history, Hawaiian history, primitive medicine, music, Polynesia, and geographic medicine. He built up a large private library. His retirement years were marred by a right hemiplegia, and by the death of his wife, Maude, in 1977. But his career as a physician was an illustrious one, and the many young men whose lives he touched will never forget his charm, grace, and wisdom. He is survived only by his children, David A. Walker, who lives on the Mainland, Richard S., on Maui, and Elizabeth, on Oahu.

We won't soon see his like again!

HARRY L. ARNOLD, JR., M.D.

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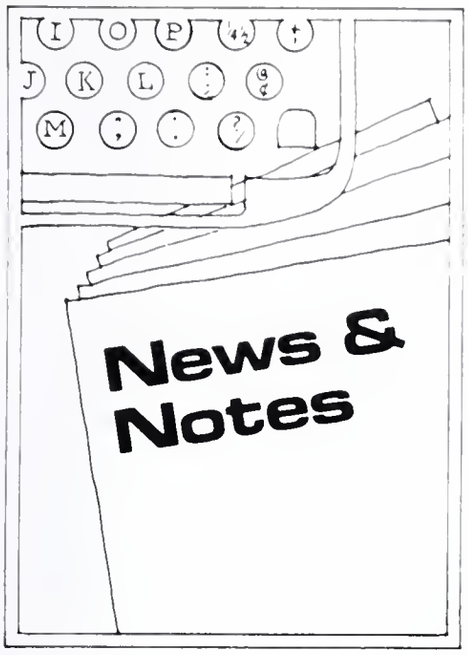
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HENRY N YOKOYAMA, M.D.

Ten Commandments For Physicians

(Submitted by Stanley Snodgrass, Executive VP, Hospital Association of Hawaii)

1. Thou shalt review thy patient's hospital bills, in order to better understand total patient costs.
2. Thou shalt familiarize thyself with drug prices, consultant fees, lab and X-ray charges, thereby learning more about health care costs.
3. Thou shalt not be persuaded toward over reliance on tests, instead, rely more upon clinical judgment and not on diagnostic procedures only.
4. Thou shalt be more selective in ordering tests. Order tests as patients' problems become clearer.
5. Thou shalt teach cost control to student physicians.
6. Thou shalt look at costs on a cost-by-case basis.
7. Thou shalt make patients' records available to covering colleagues.
8. Thou shalt provide lab and X-ray tests results to the physicians when referring a patient.
9. Thou shalt avoid late week elective admissions. The weekend wait extends the patients' stay and increases their costs.
10. Thou shalt shop around for supplies . . .

Letters to the Editor

"Henry: Re your News & Notes/HMJ 12/1980

APHORISMS: The French have one: Tout le monde veut au paradis mais on ne veut pas mourir. (Everybody wants to go to heaven but no one wants to die.)

Fred
26 Jan '81

P.S. How come no more da kine jokes? Auwe!"

(We were overjoyed to see the familiar name, the familiar humor, the long lost wit and vocal critic come alive again! Thanks for the encouragement, Fred . . . We needed that . . . esp. with censorship of "da kine jokes" becoming increasingly severe of late . . . We do sorely miss your letters to the editor in the newspapers . . . and your Family Practice column . . . (Best kine therapy, eh?)

Professional Moves

Our apologies to these people we missed back in November last year . . . Internist **Craig Shikuma** opened his office at 670 Ponahawai Street, Suite 208, Hilo, HI; Anesthesia Associates Inc. (**Luke Tajima, Edwin Ichiriu, Mitsuo Hattori, Takeshi Kishida, Frank Chang** and **Henry Watasaki**) relocated to Kuakini Medical Plaza, Suite 306; and **John McDougall MD Inc.** announced the opening of his Honolulu office at Ala Moana Bld., Suite 606 (exclusively for the treatment of dietary and chronic degenerative diseases by principles of nutrition).

On to December . . . Internist **George Suzuki** relocated to Suite 304, Kuakini Medical Plaza; Hematology and Medical Oncology, Inc. (**Noboru Oishi, Dennis Wachi,** and **Melvin Inamasu**) relocated to 1520 Liliha Street, Room 504; OB Gyn person **Sonia Zarate** opened her practice at 373 Kilani Ave., Wahiawa, Hawaii; and pediatrician **E. T. Dela Cruz** opened his office at 1405 N. King Street; **Ghim Yeoh, M.D. Inc.** announced the opening of his radiology office at the Professional Plaza of the Pacific, 1520 Liliha Street, Suite 202 . . . So much for the old year . . . Now on to the new . . .

In January, there was another flurry of activity: With the completion of the Professional Plaza of the Pacific at 1520 Liliha Street, internist-nephrologist **Dudley Seto** moved into Suite 304 and **Lawrence Winter** moved into Suite 304. Pediatrician **William Moore Jr.** relocated to Suite 205, Kahala Mall Office Center, where he will be associated with **Stephen Tenby** for the practice of pediatrics and adolescent medicine; another pediatrician, **Fernando Atienza,** relocated to Suite 805, Kuakini Medical Plaza at 321 N. Kuakini Street; and yet another pediatrician, **John Shih,** who also does pediatric cardiology opened his office at 45-955 Kam Highway, Kaneohe . . . Moving into the Queen Emma Bldg., Suite 306 at 1270 Queen Emma St. were FP **Gilbert Halpern** and internist **Charles Brown; Robert Bell** joined the Center for Clinical Hypnosis and Holistic Health at 1221 Kapiolani Blvd., Suite 1025; radiologist **Frank Voralik** opened at Suite 415, 1441 Kapiolani Blvd. limiting his practice to diagnostic ultrasound; ophthalmologist **Gary Edwards** relocated to Beretania Medical-Dental Plaza, 848 So. Beretania, Suite 307 . . . Joining the Fronk Clinic at 389 So. Beretania were ophthalmologist **Donald Sproat** and pediatrician **Art Wong** . . . Old friend **Sau Ki Wong** retired and eye men **Ming Chen** and **William Holmes** have assumed his practice at Rm. 303 Gaspar Medical Bldg., 181 S. Kukui St. Well, we hope we haven't overlooked too many. And good luck to all . . . in this Year of the Rooster—

Life in These Parts

"JUST PLAIN WEIRD: Absent from the annual, lavish Christmas bash thrown by **E. Gordon Dickey** was E. Gordon Dickey who had been arrested and was enjoying police hospitality. But the party went on—out front, it looked like a Mercedes showroom and rent-a-cops held signs that directed motorists to 'Dickey party'" (don chapman's humor . . .) (Ed: The Honolulu OB Gyn man has pleaded not guilty to charges of drug violations and Medicaid and mail fraud . . .)

St. Francis and Queen's are among 500 hospitals nationwide which have applied for "pot pills" to cope with the nausea and vomiting associated with chemotherapy . . . The "pot pills" are THC (synthetic tetrahydrocannabinol, the active ingredient in marijuana). St. Francis Hospital Cancer Dept. head **Tommy Lau** explained that "when taken as a tea or in tablet form, the effect isn't felt till ½ hr. to 1 hr. later, but it lasts longer (than when smoked)—about 4 or 5 hours." **Kevin Loh** of Queen's Hospital sees no problem about Queen's getting approval from the National Cancer Institute for participation in this new federally funded program . . . Nationally, about 24 states have legalized therapeutic use of marijuana in some form, but Hawaii isn't one of them . . .

Kohala Hospital ER is in the news again . . . Kohala physicians **Charles Morin, James Brand** and **Robert Watkins** have told **Henry Thompson,** deputy director of state Department of Health that if a contract agreement is not reached by Feb. 1, they will again discontinue emergency room services . . . The physicians are asking for $96,000 for the calendar year 1981 for a 24-hour, seven day a wek service at Kohala Hospital . . . The State is sticking to the 1980 contract which paid them $72,000 . . .

J. K. Sims, acting chief of the Emergency Medical Services has reported a shortage of at least 14 paramedics and no less than 24 EMTs . . . He feels that unless the personnel shortage is alleviated, the number of EMTs and paramedics leaving their jobs will increase. J.K. reports that more attractive career opportunities and salaries lure the ambulance technicians to other jobs. Several have left to become pre-medical or medical and dental students . . . low salary and burn-out also are factors . . ."

William Goebert, neurosurgeon-lawyer and attorney Terry Shintani have studied the 202 cases filed with the MCCP (Medical Claims Conciliation Panel) in the past 3 years and conclude that the MCCP has an impressive rate of screening malpractice cases: 75% were settled without a suit; of 139 cases that had gone through the entire hearing process, the panel found the doctor or hospital at fault in 41 cases (30%) and without fault in 98 cases (70%). In the latter 98 cases, 48 complainants (or over ½) dropped their claim; 21 filed suit anyway; 12 more were thinking about filing suit; six doctors settled out of court for amounts ranging up to $5,000; and in 10 cases, the outcome was unknown . . . Of the 41 cases the panel ruled against, 23 or 56% were settled out of court, 13 of them at the amount the panel recommended; 16 or 39% filed suit, but two were settled before trial . . . Bill Goebert says "A high number of doctors say results should be admissible. A high number of doctors win at the panel level . . . but offer to settle anyway, presumably to avoid a trial . . . That's bad, as far as I'm concerned . . . Either the panel isn't doing its job or it's incorrect."

"Anonymous" sent us the following sign to hang in our office: "NOTICE:—WHILE IN HERE SPEAK IN A LOW, SOOTHING TONE AND DO NOT DISAGREE WITH ME IN ANY MANNER . . . Please be informed that when one has reached 'my age' noise and non-concurrence cause gastric hyper-peristalsis, hyper-secretion of hydrochloric acid and rubus of the gastric mucosa . . . and I BECOME MOST UNPLEASANT!" (Ed . . . Well, 'Anonymous' meant well . . . suspect we are getting older and perhaps a bit more cantankerous of late . . ."

Appellate Judge James Burns with The Hawaii Appeals Court rejected the U.S. Supreme Court's interpretation of federal law (which allows a two year statute to start running once the cause and the damage are discovered) and further extended the time to file medical malpractice lawsuits . . . Judge Burns ruled that "the statute does not start running until the person discovers or should have discovered the damage, the violation of a duty owed to that person and the casual connection between the violation and the damage" . . . (Now it can be forever and ever . . . it seems. We may have to carry malpractice insurance nigh unto our graves . . . well, we gain an inch and lose a foot each time . . .)

"Dr. Norman Goldstein's book, 'The Skin You Live In' was excerpted in *Cosmopolitan's* new Beauty Guide . . ." (from don chapman's column)

"If it's true that the way to a man's heart is through his stomach, rookie Rep. Connie Chun (Ed: Mrs. 'Hunky' Chun) should do very well in the Legislature for constituents. Connie baked loaves of her ono ono mango bread as Christmas presents for colleagues in the House and Senate" (Also from don chapman) (Ed: That's just like Connie . . . We have not forgotten those three lovely hand made bow ties she gave us 10 years ago at a time when bow ties were unfashionable and unavailable . . .)

J. K. Sims, acting chief of the EMS branch of the state Health Dept. claims, "Hawaii's emergency medical system, now a statewide system—is one of the best in the nation . . . Since 1972, the paramedics and their ability to perform some hospital procedures on the scene of an emergency have made more and more impact on survival rates . . ." "In 1969 and 1970, before the training of paramedics began, the survival of cardiac arrest patients ranged from 0.7 to 2.7% and the survival of high risk cardiac patients was between 33 and 45% . . . Between 1976 and 1978, cardiac arrests have survived at a rate between 5.3 and 13% and high risk cardiac cases from 75 to 77% . . . The paramedics have definitely made the difference . . ."

Judd McNamara added, "What the paramedics have been able to do has been great—even phenomenal . . . in the past six years, there have been many more successes in rescuing heart and trauma patients. And today, the paramedics have a sense of pride and professionalism . . . Being a paramedic is something to be proud of . . . The people they pick up are their patients—not just bodies to be transported . . ."

It seems that all hell broke loose . . . When HEPA terminated its Kona Hospital emergency room coverage on week nights, weekends and holidays on Dec. 31 for economic reasons, the troubles just got started. **Robert Laird,** Kona Hospital chief of staff tried the regular 24 hour on-call-medical officer of the day (MOD) to be responsible for all patients coming in when HEPA was not on duty, but the extra nighttime workload forced several FP's to pull out of the MOD schedule. In an emergency executive committee meeting, it was unanimously decided to terminate the primary physician on-call emergency system as of Feb. 1 . . . Bob has called on the State to fulfill its responsibility to re-establish in-house emergency coverage at Kona Hospital . . ."

The Big Island is surely beset with its share of problems . . . **Andrew Sackett,** Dept. of Health district health officer feels that yellow jackets which came to the island in 1978 may be more than a pest and a problem on Hawaii. Andrew says, "It's kind of an emerging problem at this stage." Thus far several people have had multiple yellow jacket stings, but no one has been hospitalized because no one highly allergic has been stung so far. One Kona nest has been estimated to have 12,000 yellow jackets in it . . . Thirty to 50 nests have been found in the National Park and other nests have been found in Kamakua.

Kauai residents with arthritis are cautioned about buying DMSO (dimethyl sulfoxide, a powerful solvent derived from the wood processing industry . . .) which is being heavily advertised at $20 per pint . . . **Albert Ley,** ophthalmologist, says "the price quoted for the industrial grade DMSO is exploitation . . . DMSO is so cheap it comes in tank cars and the industrial DMSO has impurities and is not fit for human use." Orthopod **Thomas Grollman** warned that "the user of industrial DMSO takes the same risk as the drug user of street drugs . . . DMSO's adverse reactions include dermatitis (85% of users), visual problems, headaches, nausea and diarrhea." **David Elpern** says "that DMSO is so cheap that big drug companies are not interested in producing it because of the minimum profit . . . Much of the effect of DMSO may be of a placebo type. Some people will feel better if you look at them cross-eyed." (Ed: Hmmmm! We'll have to try that cross-eyed look gimmick . . .)

Oncology Dialogue

A 78-year-old man had a repeat rt nasal mass biopsy which pathologist **Larry McCarthy** ecstatically described as a lymphoma (The first biopsy was reported as carcinoma). Epidemiologist-pathologist **Grant Stemmerman** was curious, "Any history of drinking?" Oncologist **Kevin Loh** replied that the patient was a nondrinker . . . Viewing the slides, Grant asked, "Does this constitute starry sky phenomenon?" Larry replied, "More, a pseudo starry sky phenomenon . . ." The discussion then led to the possibility of staging . . . Kevin stated, "Staging is not indicated because of the patient's condition . . . They respond very well to chemotherapy without staging . . ." Radiolotherapist **Carl Boyer** who had proposed staging with CT scans, countered mischievously, "You speak with forked tongue . . . You wouldn't stage, but you will give all that horrible medicine . . ." Kevin retorted, "We give chemotherapy not as an adjuvant to radiation therapy . . ." (Ed: We have been attending the KMC oncology meetings since its outset . . . The beauty of the meetings is that most of the dialogue is meant to stimulate discussion and feathers are never really ruffled . . . There is a pervading intellectualism, wit, and camaraderie . . .)

A 69-year-old woman with a history of Ca of the cervix irradiated 15 years ago has been completely asymptomatic. She was recently found to have lung lesions and a needle biopsy showed metastatic epidermoid carcinoma. For once

oncologist **Kevin Loh** had no recommendations to offer . . . Surgeon **Glenn Kokame** took the initiative, "This may be a place for an aggressive surgical approach . . . I have a patient who did well after repeated surgeries for lung and thyroid metastases . . ." Moderator **Quint Uy** chuckled, "Well, looks like we have finally stumbled onto a surgical disease . . . Surgeon **Francis Oda** concurred with Glenn and supported the aggressive surgical approach . . . for metastatic cervical CA . . .

A 32-year-old Japanese woman had workup for an asymptomatic rt breast tumor of 1 month duration. Probably because the family history was rampant with carcinoma the surgeon performed a modified radical. . . . Radiologist **David Sakuda** commented, "Xerography demonstrated a calcified lesion on this young lady with a very dense breast . . ." Pathologist **Larry McCarthy** showed the slides and reported, "It's an intraductal carcinoma with negative nodes . . . The tumor measured 2 by 3 cm . . ." Fellow pathologist **Grant Stemmerman** added, "There is a problem with estrogen receptors when cautery is used in tumor removal. The estrogen receptors are particularly heat sensitive . . ." Surgeon **Francis Oda** piped up, "You wouldn't call this an intraductal papilloma, would you? . . . The pathologist's interpretation, whether he calls it intraductal papilloma, intraductal carcinoma or intraductal florid papillomatosis dictates the extent of our surgery . . ." Surgeon **Glen Kokame** was critical, "Here, we did a modified radical . . . It's an overkill . . ." Grant graciously defended the attending surgeon: "I disagree in this particular case . . . I would have recommended a simple mastectomy on any other breast, but she's got cancer coming out of her ears in her family history . . . She may even get colon carcinoma later . . ."

Miscellany

Watanabe san went to an eye doctor because his eye no can see good . . . After a careful examination, the ophthalmologist reported: "Mr. Watanabe, I'm afraid you have cataracts." Watanabe san replied, "No, No Doctor san . . . Me have Datsun and Toyota, but no Cadillacs." (As told by **Jon Won** . . .)

The answer is "crick." What is the question? The question is "What is the sound made by a Japanese camera?" (**Harry Arnold Jr.'s** witticism)

The answer is "Dr. Livingstone, I presume?" What is the question? The question is "What is your full name, Dr. Presume?" (Another HLA^2 contribution)

Elected, Honored & Appointed

The Blood Bank of Hawaii elected as new trustees **Henry Fong** and **Neal Winn** . . . Reelected to the board were **Russell Carlson** and **Julia Frohlich** . . . Other officers include vice presidents **Noboru Oishi** and **Drake Will** . . .

Newly elected officers of the Honolulu County Medical Society are president **Henry Fong;** president-elect **Thomas Cahill;** secretary, **Nadine Bruce;** and treasurer, **James Lumeng** . . .

Olaf Skinsnes, pathologist at the UH School of Medicine since 1967 who in 1975 successfully cultivated the leprosy bacterium in the laboratory was awarded the honorary degree of doctor of humane letters by St. Olaf College, Northfield, Minn. Olaf was born in China, served as a medical missionary in China following graduation from med school and later taught at the University of Hong Kong and the University of Chicago.

Elizabeth Anderson who received her master's degree in public health from UH has been named chief of the Medical Health Services Division of the State Health Department.

William Iaconetti of Maui Medical Group has been elected to the board of directors of HMSA . . . Bill replaces **Sakae Uehara** who has become chief of staff at Maui Memorial Hospital . . .

Physicians Speak Up

Sen. Buddy Soares had suggested discontinuance of the John A. Burns School of Medicine on grounds that the nation faces a doctor surplus. He felt that the state could pay the tuitions of Hawaii students at Mainland schools, and thereby save the expense of maintaining our own medical school. Dean **Terence Rogers** replies in a letter to the editor. Herein are excerpts: "It is an appealing argument, but it is based on a false premise: that our students could in fact find places in Mainland schools . . . They cannot . . . The Mainland states, as does Hawaii, reserve their facilities for their own residents . . .

"No one quarrels with recent studies that there will be a surplus of doctors nationally . . . It does not follow, however, that the appropriate response is to shut down the school and thereby close off opportunity for our young people . . .

"Further, it is not simply a question of total numbers of doctors; it is also a question of the kind of doctors and where they practice . . . Hawaii is well supplied with doctors in some specialties and in some areas, but has needs in other specialties and in other areas . . .

"Our school concentrates successfully on producing the doctors Hawaii needs most—primary care physicians—and in encouraging them to practice where most needed . . . The value of a medical school in Hawaii lies not only in the training of physicians, but also in the positive impact on the quality of health care which results from residency programs conducted cooperatively with the community hospitals and from continuing medical education which helps practitioners remain abreast of new developments in a rapidly advancing field of knowledge." (Ed: Terence, we note, is an advocate of Howe's Law: "Everyone has a scheme that will not work . . .")

Stanley Batkin addressing a conference on aging at Kuakini Medical Center reminded the families with elderly relatives that the "Good Book had a very important statement: 'Honor thy father and mother.' We're all unique and we all deserve respect, no matter how old we are . . . Old age and wrinkles should be worn as badges of honor . . . It is so important to understand the differences between the old and the young, and the importance of maintaining our dignity . . ." Stanley emphasized that a stimulating environment is necessary for the patient's health . . . "Aging begins when curiosity and activity end . . ."

Len Hughes Andrus, professor of family practice at the U of California-Davis School of Medicine said "the nuclear family has had a profound effect on the elderly . . . It has left them wanting, and has left them needing. The many problems that face older people are compounded by the lack of the 'old fashioned' support of the family . . . Regardless of what has happened to our social structure, we all need families . . . One of the most frequent, unmet needs of older people is the lack of a family structure, the lack of being part of a family. They need to belong, they need to be intimate . . . Families have to become involved with each other . . . Caring for the frailer, older members of society is a sign of civilization."

Thomas Cashman, director of The Healthing Center, Straub Clinic & Hospital, Inc. corrected Beverly Creamer's four part series re The Healthing Center as follows: "Her fourth column which focused on the exceedingly complex area of nutrition, however, contained a couple of inaccuracies. The article states that High Density Lipoprotein (HDL) was 'a cholesterol found in polyunsaturated fats' (in food). Actually HDL itself isn't found in food, but is manufactured by the body as a means of transporting cholesterol in the blood."

"Finally, the nutrition article quoted us as referring to research suggesting that two (alcoholic) drinks a day appears to have some beneficial effects on the HDL level in the bloodstream . . . The story neglected to say that more alcohol per day than this has no additional good effects, and furthermore, that the Healthing Center in no way advocates people drinking very high calorie, low nutrient alcoholic beverages. Instead, we teach people a variety of ways to find their own 'natural highs' in our program—through exercise, relaxation, good nutrition and improved knowledge of self . . ."

Ernie Page wrote caustically in a letter to the editor "West Hawaii Today": "The main themes of all news of late is to cut government spending . . . Our Hawaii elected officials are asking for quite a substantial salary raise; even though their records are very mediocre . . . All officials and appointees

now in office should think twice before costing the taxpayers any more; they get too much now for what poor services they give the taxpayer . . . Didn't they ever hear of 'killing the goose that lay the golden egg?' Someday they will run out of taxpayers to bleed."

Ophthalmologist **Malcolm Ing** warned about the PARADE article describing radial keratotomy for near sightedness . . . "Radial keratotomy may prove to have some merit after controlled studies are completed in this country . . . The National Advisory Eye Council strongly urges that the public be informed that this procedure is considered experimental in the U.S. at this time . . . A gentle reminder is in order that the public would be wiser to wait until fellow U.S. eye surgeons also are adding their own spectacles to the bonfire, before being swept away by such notions of 'cure.' After all, a golden rule for physicians should be simply stated: 'Offer unto others what you would have done unto yourselves.'"

Hors De Combat

"Most folks who have to deal with an 'alphabet soup' government agency (referring to SHPDA) came out of the experience cursing red tape and government inefficiency . . ." (Quote from Maui News) One Maui physician feared the agency will become more and more bureaucratic with more paperwork and less listening . . . Another physician characterized SHPDA's response as "relatively slow" . . . **Charles Probst,** chief of staff, Maui Memorial Hospital, feels that the slow response time can sometimes slow things down so much that building costs double while applicants wait for a decision . . . Charles was referring to the new wing at Maui Memorial . . . **William James** of the Maui Clinic says "the system as it is now set up tends to spawn mediocrity. It doesn't permit ongoing competition that would improve services and efficiency . . . The person who gets there first with the facility and the equipment is privileged to use it without competition . . ." (Ed: This was back in December . . . Then along came January . . .)

In January Maui physicians were again having trouble with SHPDA (which through a Federal mandate presumably decides "quality health care at reasonable costs by increasing cooperative development of resources, reducing duplication of services and promoting measures of health maintenance"). Maui Medical Group radiologist **Robert Bjornson** wants a CAT scanner, but was told that official standards require a predicted 2,000 uses per year before a scanner is considered cost-effective enough to receive a "Certificate of Need." Pediatrician **John Briley** only wanted better transportation for seriously ill or premature infants who must be sent to Honolulu for high-risk prenatal care . . .

American Samoa has its 40 cases of eosinophilic meningitis from the ingestion of raw or improperly cooked giant African Snails. The African snail reached Samoa in 1975 and the government has had three major unsuccessful campaigns to reduce the snail population. Last summer, two boatloads of Korean fishermen docked at Pago Pago and someone brought them a large basket of giant African snails. Of the 30 men in the two crews, half ate the snails raw while the other half ate them only after they had been boiled. Everyone who ate the snails raw became severely ill with meningitis and one young man died after being in a respirator for two weeks.

Arson was suspected in a $250,000 fire in December that destroyed the home of **Kenneth Haling** of Maui and slightly injured his daughter, wife and mother-in-law . . . It was the second arson-suspected fire at the Haling home where a small fire was started at their front door just two weeks earlier . . .

Northwestern Mutual Life Insurance Co. which owns both the Alexander Young Building and the adjacent Pacific Trade Center decided in December to tear down the 77-year-old Alexander Young Building despite the valiant fight by the "Friends of the Alexander Young Building." **Norman Goldstein,** spokesman for the group said, "Bah, humbug! Scrooge could take lessons from the Northwestern Mutual Life Insurance Co. . . ." The renaissance style building will be torn down starting around Feb. 1 to make room for a 29-story office building and 37,000 square foot park . . . Tenants have been asked to vacate no later than July 1 . . .

John Lennon's killer, Hawaii's own Mark David Chapman apparently sought help from two mental clinics two weeks before he left for New York . . . Chapman first contacted the Makiki Mental Health Clinic which referred him to the Catholic Social Services which made an appointment for him which he never kept . . . State mental health workers have even received telephone bomb threats from New York City as news of Chapman's history spread . . .

Psychiatrist **Emily Khaw** (bless her brave soul) stood firm by her original diagnosis that accused rapist Rodrigo Rodrigues is not a "multiple personality" case. The court appointed psychiatrist testified that Rodrigues suffers from "sexual perversion, pedophilia," and fit to stand trial . . . Two other court appointed experts and two defense experts have diagnosed Rodrigues as suffering from the rare multiple personality disorder.

When a nurse brought charges of misdemeanor against mild mannered **Ronald Hattis** of Kauai in December, Ron asked for a trial by jury to plead his case . . . So the case was moved up to Circuit Court . . . (Ed: It's about time we physicians stood our ground and stopped letting RN's run our day and our lives . . .)

Sportsmen

Jim Bennett of Kaiser had a three generation entry in the Marathon . . . Jim ran his 11th marathon, daughter Nancy ran her 4th and granddaughter Heidi, age 13, ran her first . . . (gleaned from don chapman's column)

Medical Matters columnist **Richard Adler** of Hilo ran the Honolulu Marathon . . . and was euphoric as he wrote: "The whole marathon experience was so marvelous and the training so valuable for my present and future health that I want to share it with you . . . Finishing the marathon was so exhilarating and exciting . . ."

Our "Angels"

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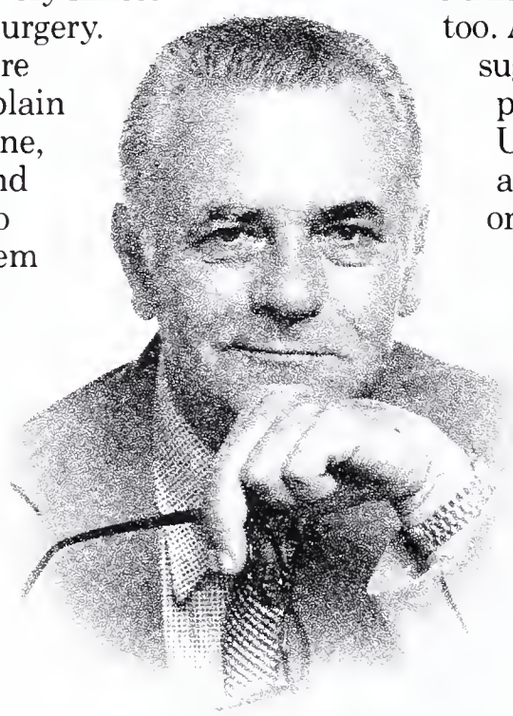
From what our HMSA members tell us, more doctors seem to be perfecting that old fashioned 'bedside manner.'

To the patient, every illness is serious, especially surgery. Today more doctors are taking the time to explain what is going to be done, why it's being done and how much it's going to cost. Patients, too, seem to be more concerned and willing to talk about these important matters.

We think these are both healthy signs. We can all do our part to promote this kind of helpful dialogue.

We'd like to hear from you, too. Anytime you have a suggestion or question, please let us know. Usually we can have an answer for you in a minute or two.

HMSA — the efficient way, for you and your patients.



Old Fashioned Dialogue is Back.

HMSA Utilization Review Department
Ph: 944-2355

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Feelings vs

Some people feel that I am misused and overused and that I'm prescribed too often and for too many kinds of problems.

The FACT is that approximately eight million people, or about 5 percent of the U.S. adult population, will use me during the current year. By contrast, the national health examination survey (1971-1975) found that 25 percent of the U.S. adult population experiences moderate to severe psychological distress. Additionally, studies of patient attitudes revealed that most patients have realistic views regarding the limitations of tranquilizers and a strong conservatism about their use, as evidenced by a general tendency to *de*crease intake over time. Finally, a six-year, large-scale, carefully conducted national survey showed that the great majority of physicians appropriately prescribe tranquilizers.

Some people feel that patients being treated with anxiolytic drugs are "weak," can't tolerate the anxieties of normal daily living, and should be able to resolve their problems on their own without the help of medication.

The FACT is that while most people can withstand normal, everyday anxieties, some people experience excessive and persistent levels of anxiety due to personal or clinical problems. An extensive national survey concluded that Americans who do use tranquilizers have substantial

Facts

justification as evidenced by their high levels of anxiety. It was further noted that antianxiety drugs are not usually prescribed for trivial, transient emotional problems.

Some people feel afraid of me because of the stories they've heard about my being harmful and having the potential to produce physical dependence.

The FACT is that there are thousands of references in the medical literature documenting my efficacy and safety. Extensive and painstakingly thorough studies of toxicological data conclude that I am one of the safest types of psychotropic drugs available. Moreover, I do not cause physical dependence if the recommended dosage and therapeutic regimen are followed under careful physician supervision. However, I can produce dependence if patients do not follow their physicians' directions and take me for prolonged periods, at dosages that exceed the therapeutic range. Patients for whom I have been prescribed should be cautious about their use of alcohol because an additive effect may result.

Many of the most knowledgable people feel that I became the No. 1 prescribed medication in America because no other tranquilizer has been proven more effective. Or safer.

The FACT is they are right.

For a brief summary of product information on Valium (diazepam/Roche) Ⓡ, please see the following page. Valium is available as 2-mg, 5-mg and 10-mg scored tablets.

Valium®(IV)
diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy)
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.
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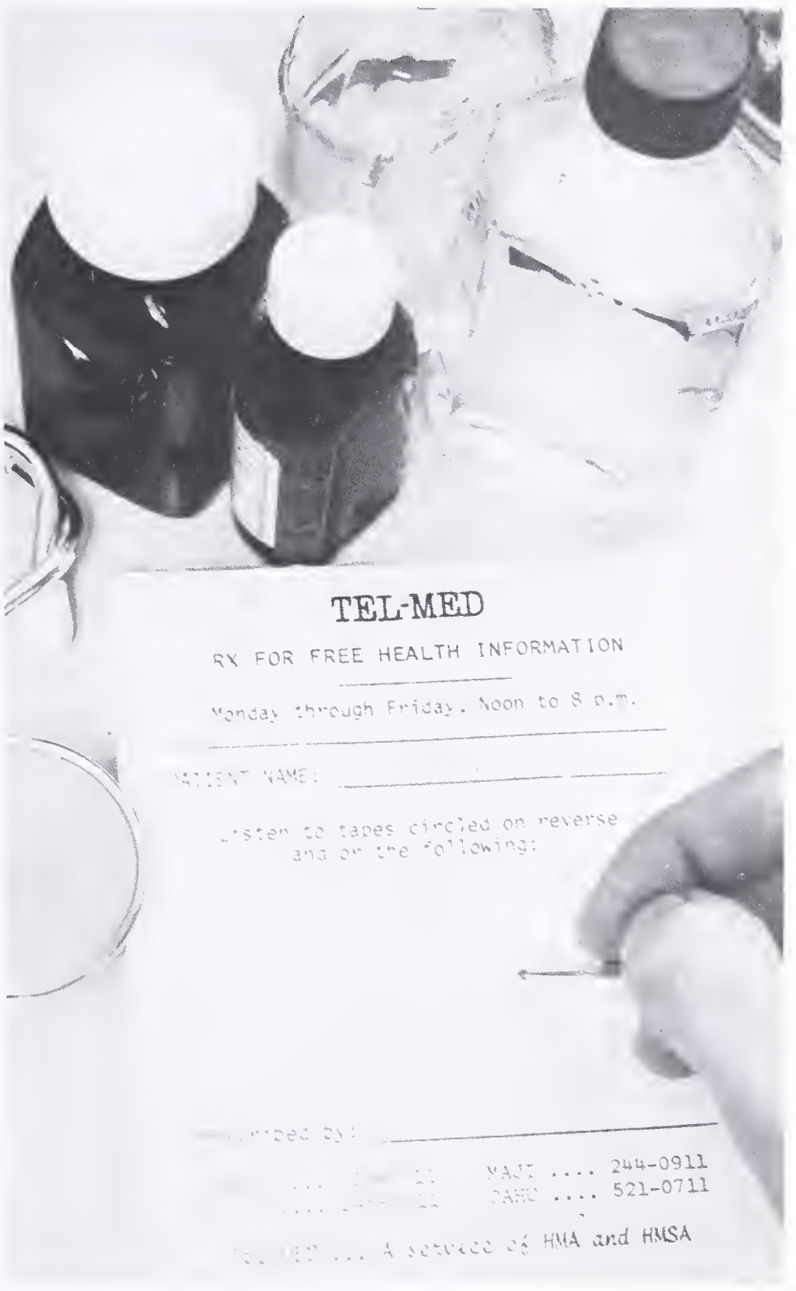
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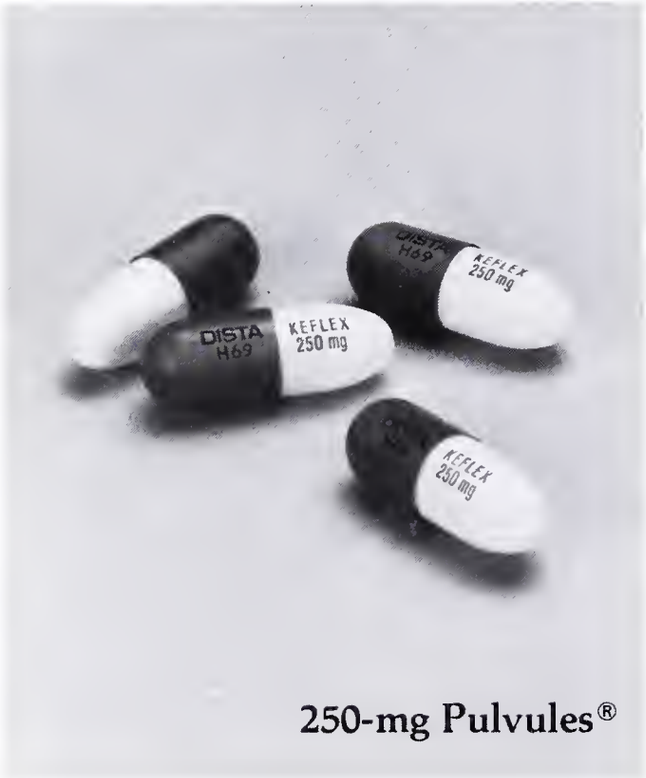
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Careful attention to cuts will reduce morbidity . . .

Treatment of Coral Cuts in Hawaii

MAXWELL A. COOPER, M.D., *Honolulu*

Wounds received from collision with reef or rock in Hawaiian waters are collectively called coral cuts by the walkers, waders, fishermen, swimmers, surfers, and skin- and scuba-divers subject to them. Such wounds are characterized perhaps more than anything by notoriously stubborn healing and propensity to infection. Skillful management of these wounds can reduce an otherwise considerable morbidity.

Coral is largely calcium carbonate laid down in regular pattern, much like the Haversian system of bone, by a marine animal, the coral polyp. The animals themselves, ranging in size from microscopic to several millimeters, are soft and inflict no injury to man except for several varieties of stinging corals (fire corals) which can give painful wounds by injection from microscopic nematocysts. Species about the Hawaiian chain rarely give more than moderate pain and erythema lasting several hours. If coral nematocysts are introduced through an open wound they may cause a more significant local tissue reaction. Further south and west in the Indo-Pacific, the toxicity of stinging corals increases.

The polyp is a delicate animal which dies after as little as 20 minutes exposure out of water. Should it be introduced into human soft tissue, it would succumb quickly to the body defenses. Proliferation of the polyp in injured tissues is not responsible for the poor healing seen in these wounds.

Several complicating factors contribute:

1. These wounds frequently involve the lower extremities. The quality of the dermal circulation in man decreases craniocaudally, and the reliability and quality of wound-healing is directly related to tissue blood supply. Leg wounds, especially pretibial wounds, heal slowly. Patients over 40 years of age and those with specific angiopathy (diabetic, Buerger's) should not have their leg wounds closed surgically.
2. The nature of wounding is traumatic relative to Halstead's "ideal" wound made with scalpel. Wound edges are often irregular, contused and crushed and have a greater degree of cell injury and necrosis. Abrasion creates epithelial loss and a second or third degree wound rather than a simple laceration.
3. The wounds are contaminated. Pathogenic bacteria are found in shore waters. The marine algae, which are loosely adherent to much of the fringing reef and lava rock, sediment and the sometimes rather crumbly coral itself, can be implanted as foreign body.
4. Those injured are usually active in the water. Limited patient compliance may compromise optimal wound care by continued activity and immersion.

Accepted for publication August, 1980.

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Prevention

Exercising common sense and basic water safety should limit many such injuries. Advice offered during the treatment process is certainly reinforced at the time, even if not always heeded:

1. Know the bottom where you wade or swim.
2. Keep one eye on your footing and one eye on the surf.
3. Avoid dangerous shoreline and difficult water conditions.
4. Wear adequate protection.

Tennis shoes or reef boots, gloves and long pants make snorkeling or reef walking safer and easier. Bare legged shore divers and snorkelers usually have leg scars.

Treatment

First aid management is as for similar wounds of any other etiology. Urinating into coral cuts is not therapeutic (although not deleterious). The solvent capability of urine versus calcium carbonate is quite overrated. Sphincter relaxation under shoreline conditions can be difficult, and attempts have been known to offend tour groups.

Significant wounds usually lead the victims to seek medical attention. Associated major injuries take precedence, and occult injury should be searched for actively. Most commonly, the wounds involve the skin and subcutaneous tissues only, but involvement of deeper structures may create challenging surgical problems.

Treatment requires surgical washing, exploration, perhaps hemostasis and debridement, and certainly removal of foreign body.

Anesthesia may be required; usually infiltration of local anesthesia through the wound edges suffices. Good hemostasis, light and exposure are needed for gentle but thorough inspection and probing of all reaches of the wound for meticulous removal of foreign body. Copious irrigation with saline should follow. The process is repeated until all visible foreign body is picked out, cut out or washed out. Irrigation with ammonium chloride has been advised. Solutions of significant concentration are painful and are destructive to exposed tissue. Mechanical debridement and saline flushing are better ways of removing the coral substance.

Leg wounds are usually best treated by simple dressings or, at most, tape stripping. Attempts at suture of leg wounds often result in wound abscess and then a much more difficult closure problem. Face and scalp wounds can almost always be converted to surgically clean wounds and closed primarily. Minimal to no debridement of facial tissue is required. Upper extremity and trunk wounds are in-between, both anatomically and therapeutically. More surgical judgement is required; weighing the time since wounding, degree of tissue trauma, degree of contamination, and individual wound-healing characteristics; but many of these wounds can be closed primarily. Wounds left to heal secondarily usually heal with a satisfactory result, and avoid abscess but prolong morbidity. When there is doubt or inexperience on the part of the physician, simple wounds are best left open or closed with tapes only.

The fewer the sutures, the better. If closure can be achieved with tape strips, that is preferred. Buried sutures should be absorbable and few. Tight skin sutures and sutures left in longer than 5 days leave suture marks. Silk sutures likewise cause more inflammation than nylon and are more likely to leave marks.

A non-stick permeable inner layer and an absorbing outer layer make a basic dressing. Any sort of gauze over single layer Xeroform is very acceptable. Topical ointments will likewise prevent the outer dressing and the environment from sticking to the wound. A light pressure dressing where practical is useful for 24 to 48 hours. Tourniquet effect with subsequent swelling must be avoided.

Rest and elevation of the injured part are elementary measures that some patients don't think about unless they're instructed. Sutured wounds with good apposition are sealed to external contamination by 48 hours. Patients need not forego bathing the wound, sutures and all, after that period. They can usually dispense with the dressing as well. Daily showering for open wounds with gentle drying and rebandaging by the patient is permitted. Sterile technique is not required, only simple hygiene.

Coral cuts are tetanus prone wounds and may require tetanus prophylaxis, based on the patient's immunization history. Antibiotics given prophylactically are probably not useful. Effective use of prophylactic antibiotics requires that they be given before wounding. However, giving antibiotics for dirty, old or badly traumatized wounds or those with exposed bone or cartilage is standard practice. Topical antibacterials are usually not required. Established cellulitis or abscess require broad spectrum antibiotics adjusted to culture results.

Hypertrophic scarring, especially where the extremities are injured and in brown-skinned patients, is not unusual with this sort of traumatic wounding. Usually only limited results are obtained with scar revision of extremity or trunk scars, but patients unhappy with such scars can benefit from consultation, usually six to twelve months after injury. Facial scars are an exception and can often be improved significantly.

The normal scar maturation process is slowed by sun exposure. Effective water resistent sunscreens (Sundown, Eclipse) are worthwhile when applied daily for several months to sun-exposed scars while the induration and redness fades from them.

On balance, what risk is this, properly treated, for life in paradise?

Hemoccult Screening for Colon Cancer by Hawaii's Physicians

JOHN N. WITHERS, M.D., F.A.C.S., *and* JAMES W. WIENKE, M.D., *Kahului, Maui*

For the year 1980, the American Cancer Society estimates that, for the first time, cancer of the lung, with 117,000 new cases, will exceed cancer of the colon and rectum, with 114,000 cases.[1] *However, cancer of the lung remains a 90% fatal disease, even if discovered early by screening methods,*[2] *while cancer of the colon and rectum is potentially a highly curable cancer, with screening programs reporting 80% 15-year survivals.*[3]

The Hawaii Tumor Registry in 1978 reported 337 cases of colorectal cancer, as compared to 330 lung and 293 breast cancers. If these 337 colorectal cancers follow the 60% national average of mortality from the disease,[4] then 202 of these patients will finally die of their cancer.

It is known that the earlier the cancer is found in regard to its penetration of the bowel wall, the better are the chances for cure by surgery.[5,6] Many investigators have demonstrated that cancer of the colon can be detected at an asymptomatic and early stage with the use of the Hemoccult test.[7,8,9] Whether this test is being utilized in the community, and whether it is effective in helping physicians discover asymptomatic cancers of the colon and rectum are important considerations.

Method

A questionnaire was developed, and, with the assistance of the Maui Unit of the American Cancer Society, was mailed to 910 physicians throughout the State of Hawaii. Questions were asked about specialty, practice location, age of the respondent, knowledge of the Hemoccult test, frequency of usage on patients, and personal use of the test by the respondent and his/her spouse. Whether the physician used 6, 3 or fewer than 3 Hemoccult slides per patient, and how the positive patients were later examined, with barium enema, sigmoidoscopy, or colonoscopy, were queries. Finally, the physicians were asked whether they had found asymptomatic colon cancers with this test, how many, and whether they believed the cost of the subsequent exams to be too great for the occasional cancer found.

With the assistance of the Community Cancer Program of Hawaii and the Cancer Center of Hawaii, the returned questionnaires were analyzed by computer.

Results

A total of 315 physicians (35%) returned the questionnaires. These included 71 family physicians, 69 internists, 44 surgeons, 4 gastroenterologists, 26 obstetrician-gynecologists, 19 pediatricians, and 82 other physicians, including pathologists, neurosurgeons, orthopedic surgeons, and other non-primary case specialists. Physicians practicing on Oahu comprised 78% of those responding, 9% being on Maui, 9% on Hawaii and 3% on Kauai. Physicians over the age of 40 were 71% of the respondents. Specialists doing no primary case amounted to 27%.

The Hemoccult test was known to 93% of the respondents, and, although 86% believed it to be valuable in colon cancer detection, 2% believed it was not; 12% failed to answer that question. Frequently using the test were 51%, and 14% never used the test.

Asymptomatic colon cancers discovered with the Hemoccult test were reported by 66 physicians (21%). The total number of cancers found exceeded 164. To the question, "How many cancers have you found?", 2 physicians answered, "Several" and one answered "One a month."

Only 12% of the physicians over the age of 40 had taken the test on themselves during the previous year, and 10% of spouses over the age of 40 had been tested. Four physicians (1.3%) believed that the cost of the follow-up exams exceeded the

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Table 1

	PHYSICIANS USING: 6 SLIDES/PATIENT (20)	3 SLIDES/PATIENT (102)	LESS THAN 3 SLIDES/PATIENT (90)
% of physicians who have found an asymptomatic cancer	65%	38%	23%
# of cancers found/physician	3.0	.8	.4
% of physicians ordering BE or BE w/air on positive patients	60%	49%	35%
% of BE's being with air	75%	42%	37%
% of physicians sigmoidoscoping all	80%	83%	72%
% of physicians colonoscoping all	5%	3.9%	2%
% of physicians ordering colonoscopy if BE & sigmoidoscopy are negative	50%	50%	45%

Table 2

	FAMILY PRACTITIONERS (71)	INTERNISTS (72)	SURGEONS (45)	GASTRO-ENTEROLOGISTS (4)
Believe that Hemoccult test (HOC) is valuable	98%	95%	97%	100%
Frequently order the test	67%	81%	51%	100%
Never order the test	2%	1%	6%	0%
Order the test on annual PE's	60%	72%	51%	75%
Order the test if GI symptoms are present	87%	96%	85%	100%
Order the test on every patient over the age of 40	26%	33%	32%	50%
Have discovered asymtomatic colon cancer with HOC	28%	38%	13%	75%
Number of colon cancers found	39	77	27	20
Cancers found per physician	.55	1.07	.6	5.0
If HOC's positive order				
BE or BE w/air	33%	47%	46%	75%
Sigmoidoscopy	69%	80%	69%	75%
Colonoscopy	8%	1%	2%	25%
If BE and sigmoidoscopy are negative then order colonoscopy	46%	37%	46%	50%
Believe that cost is too great	1%	2%	0%	0%
Use 6 slide HOC	5%	11%	4%	75%
% that have found CA	50%	50%	100%	100%
Use 3 slide HOC	52%	50%	33%	25%
% that have found CA	40%	41%	33%	0%
Use less than 3 slide HOC	36%	43%	20%	0%
% that have found CA	19%	45%	0%	0%

value of the occasional cancer found. Asymptomatic colon cancers had been found by 65% of the 20 physicians who utilize 6 slides per patient, by 38% of the 102 physicians who utilize 3 slides, but by only 23% of the 90 physicians who utilize less than 3 slides per patient (Table 1). The physicians who were most likely to use the Hemoccult test were compared as to their utilization, follow-up of "positive patients," and the success in finding asymptomatic colorectal cancers, (Table 2).

Of the 98 physicians who "frequently use the test," but had never found an asymptomatic colon cancer, it was learned that in their investigation of the "positive patient," 61% did not order a barium enema or a barium enema with air, 27% did not order a sigmiodoscopy, and 58% would not have ordered a colonoscopy if the previous tests had been performed and were negative.

Discussion

The value of the Hemoccult test in detecting colon and rectal cancers at an asymptomatic stage is demonstrated by more than 164 such cancers discovered in Hawaii by 66 physicians. Unfortunately, the stage of the disease was not asked for by the questionaire, but in the experience of the authors and other investigators, these cancers are usually in an early and curable stage.[7,8,9]

Large studies are in progress at the University of Minnesota and Memorial Sloan-Kettering Institute, New York, to evaluate these impressions.[10] In this survey, it is demonstrated that primary care physicians (family physicians and internists) strongly believe in the test (97%) and ordered it if GI symptoms were present (91%). However, they use the Hemoccult test less frequently on annual examinations (66%) or routinely on persons over the age of 40 (29%), which are the opportunities to discover the colon cancers at an asymptomatic and potentially curable stage. It has long been known that physicians treat their patients better than they do themselves. This is once again illustrated by this study where only 12% of Hawaii's physicians over the age of 40 had the Hemoccult test on themselves this last year.

In the detection of asymptomatic colon cancers, the number of Hemoccult slides used ap-

pears significant, as those physicians who use 6 slides per patient have had a greater success rate than those using less than 3 slides per patient (65% vs 23%). However, these physicians also investigate their patients more diligently with barium examinations and especially with the barium enema with air contrast, (Table 1). There appears to be no difference between these groups as to the percentages of physicians ordering sigmoidoscopies or colonoscopes.

Although only 4 gastroenterologists answered the questionaire, we hoped their responses would help us evaluate an "ideal" approach to the Hemoccult test and the follow-up of positive patients. Use of 6 slides per patient was stated by 3; the one using 3 slides per patient has yet to find an asymptomatic cancer. Three will do B.E.'s or B.E.'s with air and sigmoidoscopy in the investigation of patients with positive Hemoccults, and the other colonoscopes all patients. Their success is shown by the 20 asymptomatic cancers found by 3 of the 4 gastroenterologists.

Summary

It is demonstrated that asymtomatic colon cancers are most often discovered by those physicians who utilize the 6-slide Hemoccult test and perform a thorough follow-up of the positive patients.

We strongly recommend that the 6-slide Hemoccult test be used annually on all patients 45 years of age and older (at 30-35 years of age if there is a family history of colon cancer), and that all positive tests be investigated with a barium enema with air and a sigmoidoscopy. If these tests are negative, then a colonoscopy is indicated.

Acknowledgements

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2) Gary Murfin, Ph.D., Community Cancer Program of Hawaii.
3) And to all the Hawaii physicians who took the time to answer the questionaire so that we could better serve our patients.

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The Joke's On Us!

It all sounded so innocuous when Public Law 89-97, entitled "Health Insurance for the Aged," was written July 30, 1965. Section 1801 of the law still reads as follows:

"Nothing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided, or over the selection, tenure, or compensation of any officer or employee of any institution, agency, or person providing health services; or to exercise any supervision or control over the administration or operation of any such institution, agency, or person."

Guess they were only kidding. Judge the future by the past.

JMC

Our Federal Sow

The lady was trying to justify the workings of an unorthodox rehabilitation program for youngsters. When I gently suggested that the methods were of no proven merit and the costs excessive, she shrugged and agreed that the results were meager. "But it's okay," she apologized. "It's a Federal Grant." In other words, we needn't expect much benefit from a government program; they'll fund almost anything. Why expect people 6,000 miles away to know what's best for Kalihi? Besides, Washington money doesn't cost us anything; if we don't spend it, someone else will get it.

That's the rub, of course. If the community were asked to support this scheme on the basis of merit, the program simply would not exist. And yet, the peoples' earnings are confiscated to provide projects they might not willingly support. Thus, while individuals are deprived of money to purchase programs of local importance, the community is deprived of neighborhood support. And since grantors in Washington are scarcely accountable for results, a cynicism develops in the giver and the taker when dealing with this "free" money, which needn't be as carefully spent as "real" money.

If Medicaid were entirely state supported, would our liberal program not shrink immediately? Would we willingly pay for the cavalier behavior of the local Drug Enforcement Agency? Would islanders support the Food Stamp burden or the new HMOs if they had to pay the bill? Would local motorists have bought the police those radar guns they got from Washington?

Consider all those Federal Grants with which you're familiar. If local taxpayers had to pick up the tab, wouldn't most of these programs disappear? Would it even *matter?* (Those few activities of sufficient importance to be funded by the community would work better under local management, anyway.)

Because nobody spends another's money as prudently as his own, all governments are relatively wasteful, although local government remains under community supervision. But national administrations seem almost to cast our dollars to the wind. The only cure is to cut off their supply of our money. Why not drop a note of encouragement to our President and Congressmen? About 90% of the fat has yet to be sliced off our federal sow.

JMC

Is There A Health Provider in the House?

Long ago when people asked us physicians what sort of work we did, we commonly replied "doctor." There was occasional confusion with veterinary and dental doctors, but the public generally knew who the real doctors were. But then podiatric and chiropractic "doctors" were created, to capitalize on the term. When even Ph.D.'s of music and psychology adopted the title, we retreated to the word "physician," to clarify our profession as doctors of healing.

But then came Medicare and Medicaid, perceived as Santas bestowing gifts on all who could squeeze under the medical umbrella. Naturopathic "physicians" suddenly appeared, followed closely by podiatric and chiropractic "physicians." Any group remotely connected with illness (or its opposite, "wellness") vigorously lobbied for status as "health care providers." Degrees were created to support the claim: the incredible ascent from "optometrist" to "doctor of optometry" and now to "optometric physician" was achieved without adding a day to the curriculum. Recent fabrications incorporate the word "medicine," as in Doctor of Podiatric Medicine or Doctor of Optometric Medicine.

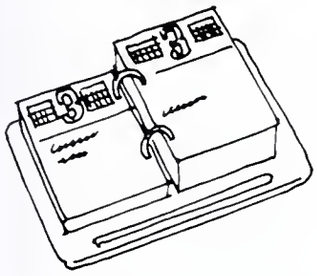
Even medical "delivery systems" are being redefined. This month one group of medical

pretenders confidently assured their state legislature, "There are now five primary care professions: Medicine, Dentistry, Osteopathy, Optometry, and Podiatry."

To reduce this confusion many physicians simply use their degree, M.D., to specify their occupation. But beware: it sounds like "N.D." (Doctor of Naturopathy) and looks like "O.M.D." (Doctor of Optometric Medicine).

Better move over, doc. The self-annointed new members of the "medical care team" are making things a little crowded for us "health providers."

JMC



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ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, First Thursday, 12:45 p.m. and Fourth Tues. 12:30 p.m. w/Maui Mem. Hsp. Held on Oahu at Am. Cancer Society main conf. room, 200 N. Vineyard, Honolulu.

John A. Burns School of Medicine

1. Dept of Medicine
 - A. Case Conferences, Second and Fourth Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 - B. Grand Rounds, First and Third Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 - C. Endocrinology Grand Rounds, Third Wednesdays, 5:30-6:30 p.m., Queens University Tower, Room 506.
 - D. Hematology Grand Rounds, Second and Fourth Mondays, 12:30-1:30 p.m., Queens University Tower, Room 721.
 - E. Cardiology Grand Rounds, First and Third Tuesdays, 5:30-6:30 p.m., Queens University Tower, Room 508.
 - F. Infectious Disease Grand Rounds, Second and Fourth Tuesdays, 5:00-6:00 p.m., Queens Nalani 1 Conference Room.
 - G. Dermatology Grand Rounds, Second Wednesday, 7:30-8:30 a.m. Queens, Queen Emma Clinic.
 - H. Pulmonary Grand Rounds, Second and Fourth Thursdays, 4:30-5:30 p.m., Queens Kamehameha Auditorium.
2. Division of Nuclear Medicine
 - A. Technical aspects of Nuclear Medicine, Second Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506, 1½ credits.
 - B. Rounds, Fourth Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506.
3. Dept. of Obstetrics and Gynecology
 - A. Grand Rounds, Wednesday 7:30-8:30 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
4. Division of Orthopaedics
 - A. Fracture Conference, Tuesdays, 5:00-6:00 p.m., Queens University Tower, Room 618.
 - B. Shriners Hospital Conference, Tuesdays, 7:15-9:15 a.m., Shriners Hospital.
5. Dept. of Pediatrics
 - A. Grand Rounds, Thursdays 8:00-9:00 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 - B. Pediatric Conference, Mondays 12:45-1:45 p.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 - C. Pediatric Infectious Disease Conference, Thursdays, 12:30-1:30 p.m., Kapiolani-Children's Medical Center, Third Floor Conference Room.
 - D. Neonatal Ground Rounds, Fridays, 8-9:00 a.m., Kapiolani-Children's Medical Center, Administrative Conference Room.
6. Dept. of Psychiatry
 - A. Grand Rounds, Fridays 8:00-9:30 a.m., Queens University Tower, Room 618.
7. Dept. of Surgery
 - A. Grand Rounds, First, Second and Third Saturdays, 7:30-9:00 a.m., rotating hospitals.
 - B. Statistical M and M, last Saturday, 7:30-9:00 a.m., rotating hospitals.
 - C. Journal Club, First and Third Tuesdays, 6:00-8:00 p.m., Queens University Tower, Room 620.
 - D. Medical-Surgical G.I. Rounds, Second Tuesday, 7:00-8:00 a.m., Queens University Tower, Room 506.
8. Depart of Family Practice
 - A. Conf., Wednesdays, 8-9:00 a.m. Kaiser 4th Floor Conf. Room.
 - B. Conf., Thursdays, 12-1:00 p.m. Kaiser 4th Floor Conf. Room.
9. Department of Physiology
 - A. Dept. Conf., Wednesday, 4:30-5:30 p.m. BioMed T-210.
10. University of Hawaii, John A. Burns School of Medicine Grand Rounds, Third Thursday, 4:30-6:00 p.m., Queen's University Tower, Room 618 or BioMed Building.
11. HI Oncology Group, one Monday a mnth., 12:30-1:30 p.m., The Cancer Center, 1236 Lauhala St., 4th Floor Conference Room.

Federation of Emergency Medicine-Maui

1. **Cardiology for the Emergency Physician.** Every Monday, 9-10:00 a.m.-Maui Memorial Hsp. Conf. Rm #1. (For spec. topics or further info. contact: Federation Office (808) 244-7629, or Dr. C. T. Mitchell, (808) 244-9056.
2. **Journal Club in Emerg. Medicine.** 2 hrs. Cat. 1. MMH Conf. Rm. #1. 9am-11 a.m.
 4/20/81 Annals of Em Med, 12/80; Abstracts in EM 1/81 - S. Burkle
 5/25/81 Annals of Em Med, 1/81; Abstracts in EM 2/81 - P. McCallum
 6/22/81 Annals of Em Med, 2/81; Abstracts in EM 3/81 - J. Mills

7/20/81 Annals in Em Med, 3/81; Abstracts in EM 4/81 - C. Mitchell
8/24/81 Annals in Em Med, 4/81; Abstracts in EM 5/81 - D. King

Hawaii Thoracic Society

1. Pulmonary Med., Clinical case presentations & current research in pul. med. with U of H sinclair Chest Club. Third or Fourth Wed., ea month, 7:30 p.m.-9:30 p.m. For further info contact: Rosemary Respicio, B.S.N. at (808) 537-5966.

Hickam Clinic

1. Clinical Correlation Conference, First Thursday, 11:00 a.m.
2. Didactic—our staff, Second Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, Third Thursday, 11:00 a.m.
4. Radiology Conference, Fourth Thursday, 11:00 a.m. (Contact Aurora Macapinlac, M.D., M.C., 449-5770)

Hilo Hospital

1. Orthopedic Conference, First Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, Second Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, Third Friday, 12:30-1:30 p.m.
5. C.P.C., Second Friday, 12:30-1:30 p.m.
6. Visiting Professor's Program

Kaiser Hospital

1. Medicine Grnd. Rnds. Every Tues. 8 a.m. Pac. Aud. 1 hr. Cat. 1.
2. Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. 1.
3. OB/Ped. Perinatal Mortality Conf. Last Tues. ea. mnth. 8:00 a.m. 1 hr. Cat. 1.
4. Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. 1.
5. Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. 1.

(Contact CME Dept.-Kaiser for further information)

Kapiolani-Children's Medical Center

1. Pediatric Grnd. Rnds. Every Thursday, 8-9:00 a.m. Aud.
2. Pediatric Conf. Mondays, 12:45-1:45 p.m. 2nd Floor Aud.
3. Neonatal Grnd. Rnds., Fri. 8-9:00 a.m., Conf. Rm. B.
4. Pediatric Infectious Disease Conf., Thursdays, 12:30-1:30 p.m. 3rd Floor Conf. Rm.
5. Ob-Gyn Conf. Tues. 1-2:00 p.m. Aud.
 First—Didactic Presentation
 Second—Perinatal-Neonatal Topics
 Third—Obstetrics Topics
 Fourth—Gyn Topics
6. Tumor Brd.—Oncology Conf. First and Third Fri. 1-2:00 p.m., Aud.

Kuakini Medical Center

1. Department of Ophthalmology Meeting, First Tuesday, 12:30-2:00 p.m.
2. G. I. Conference, First Tuesday, 8:00-9:00 a.m.
3. Department of Medicine Meeting (Statistical), Fourth Tuesday, 1:00-2:00 p.m.
4. Nephrology Conference, Second Wednesday, 8:00-9:00 a.m.
5. Oncology Conference, Every Thursday, 7:30-8:30 a.m.
6. Pulmonary Conference, First Thursday, 1:00-2:00 p.m.
7. Surgical Conference, First & Second Friday, 12:45-1:45 p.m.
8. Surgical Mortality & Morbidity Conf., Fourth Friday, 12:45-1:45 p.m.
9. Visiting Professors Programs

Maui Memorial Hospital

1. Thurs. Conf. 7-8:00 a.m. Staff Dining Rm.
 1st—Dept. of Medicine
 2nd—Dept. of Surgery
 3rd—Dept. of OB/GYN
 4th—Dept. of Pediatrics
 5th—Elective
2. Tumor Brd. every Mon. 12:15-1:15 p.m.—Tumor Conf. Telephone Task Force—Third Tues. 12:15-1:15 p.m.
3. Dept. of Emergency Med., Third Mon., 7-8:00 a.m.
4. Diagnostic Radiology—Fourth Tues., 12-1:00 p.m.
5. SFH-UH Hematology Conf., Third Thursday, 12:30 p.m.Sullivan-4 Classroom.
6. SFH-UH Surgical Grand Rounds, First, Second, & Third Fridays, 7:30 a.m., Sullivan-4 Classroom.
7. Visiting Professor Programs (for further infor call CME office at St. Francis).

The Queen's Medical Center

1. ENT Conferences, First and Second Fridays, 7:30 a.m., Small Dining Room.
2. Medical Conferences, Every Friday, 8:00 a.m., Kam Auditorium.
3. Ob/Gyn Conferences, Second and Fourth Mondays, 1:00 p.m., Kam Auditorium.
4. Ophthalmology Conference, Fourth Tuesday, 5:00 p.m., Queen Emma Eye Clinic.
5. Orthopaedic Conferences, Every Wednesday, 7:00 a.m., Kam Auditorium.
6. Pathology Conferences, Every Wednesday, 7:30 a.m., Surgical Conference Room.
7. Pediatric Grand Rounds, Fourth Thursday, 12:30 p.m., Nalani 1 Conference Room.
8. Surgical Trauma Conference, Second Tuesday, 4:30 p.m., Kam Auditorium.

 Basic Science Lectures, Every Wednesday, 7:15 a.m., Queen's University Tower, Room 618.

St. Francis Hospital

1. SFH-UH Tumor Conf., Every Monday, 7:30 a.m. Sullivan-4 Classroom.
2. SFH-UH Nephrology Conf., First Monday, 1:00 p.m. Sullivan-4 Classroom.
3. SFH-UH Endocrine Conf., last Monday, 12:30 p.m. Sullivan-4 Classroom.
4. EENT Meeting, First Tuesday, 7:00 a.m., Sullivan-4 Classroom.
5. SFH-UH Hematology Conf., Third Thursday, 12:30 p.m. Sullivan-4 Classroom.
6. SFH-UH Surgical Grand Rounds, First, Second, & Third Fridays, 7:30 a.m., Sullivan-4 Classroom.
7. Visiting Professor Programs (for further infor call CME office at St. Francis).

Straub Clinic & Hospital

1. Straub Professional Seminar meets the Second Tuesday of each month, from 5:00-6:30 p.m. in the Credit Union Meeting Room (2nd Floor, Credit Union Bldg).
2. Surgical Mortality and Morbidity Conference meets every Fourth Thursday of each month, from 7:00-8:00 a.m. in the Doctors' Dining Room.
3. Cardiac Surgery Conference meets the Third Tuesday of each month, from 4:30-5:30 p.m. in the Doctors' Dining Room.
4. Department of Anesthesiology meets the Second Tuesday of each month from 7:00-8:00 p.m. in the Doctors' Dining Room.
5. Community Peripheral Vascular Conference meets the Fourth Thursday of each month from 5:00-6:30 p.m. in the Doctor's Dining Room.
6. Visiting Professor Program meets monthly from 7:00-8:00 a.m. in the Doctors' Dining Room.
7. Urology Inservice meets every other month on the Third Friday from 8:00-9:00 a.m. in the Doctors' Dining Room.

8. Neuropathology Clinical Correlation Conference meets the Third Thursday of each month from 7:30-8:30 a.m. in the Straub Morgue.
9. OB-GYN Pathology meets every Fourth Monday of each month from 12:30-1:30 p.m. in the Administration Conference Room (ACR).
10. Urologic Pathology meets every First Monday of each month from 8:00-9:00 a.m. in the Doctors' Dining Room.
11. Friday Noon Conference meets every Friday of each month from 12:30-1:30 p.m. in the Doctors' Dining Room.

*Note: All conferences are subject to change. Monthly calendar will be available upon request.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—Second Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Miscellaneous

HMA Maternal and Perinatal Mortality Study Cmte. First Monday ea. month-7:00 p.m. 320 Ward Ave., S 200. Cat. 1 on hr. for hr. basis.

SPECIAL EVENTS

Apr. 4, 12, 1981	Calif. Soc. of Anesthesiologists. Dr. Norman R. Catron, Exec. Dir., 100 S. Ellsworth Ave., San Mateo, CA 94401. Held: Kauai Surf, Kauai, HI.
Apr. 4, 11, 1981	Current Concepts in OB/BYN. U of Wash CME SC-50, Seattle 98195. Co-spons: Wash State Med. Assn., J.A. Burns Schl of Med Held: Kona Surf, Kona, HI. 49 hrs. Cat. 1.
Apr. 4, 5, 1981	Fourth Annual Acute Care Seminar. Queen's Medical Center, 1301 Punchbowl St., Honolulu, 96813. 12 hrs. Cat. 1. Contact: CME Dept. Queen's (808) 547-4484.
Apr. 10, 17, 1981	Med. Imaging in Kauai. Am. Coll of Med Imaging, Box 27188, L.A., CA 90027. Held: Kauai Surf Htl., Kauai, HI. 24 hrs. Cat. 1.
Apr. 11, 18, 1981	Drug Therapy & Infectious Diseases. U of Wash., CME SC-50, Seattle, 98195. Held: Royal Lahaina Htl Maui, HI. 49 hrs. Cat. 1.
Apr. 11, 18, 1981	Office Management of Chronic Pain. U of Wash, CME SC-50, Seattle 98195. Co-spons: Wash State Med. Assn. Held: Wailea Beach Htl., Maui, HI. 49 hrs. Cat. 1.
Apr. 12, 18, 1981	"Practical Aspects of Health Promotion; Skills for Disease Prevention in Communities." Spons: Harvard U Sch of Public Hlth, U of Kuopio, & International Cntr for Hlth Ed. Held: Kauai Beach Htl, Wailua, Kauai, 25 hrs. Cat. 1. Contact: Robert Schmidt, M.D., Internat'l. Cntr for Hlth Ed., P. O. Box 3109, Lihue, Kauai HI 96766 (808) 245-2121.
Apr. 18, 25, 1981	Emergency Medical Care: Trauma, Orthopaedics & Surgery, U of Wash, CME SC-50, Seattle, 98195. Held: Wailea Beach Htl, Maui, HI
Apr. 25, 1981	"Type A Behavior & Your Heart." Spons: HMA/Well-Being, Inc. 8-10:00 a.m. Mable Smyth Aud., Honolulu. Contact: Well-Being, Inc., 3130 Beaumont Woods Pl., Honolulu 96822 (808) 988-2940.
Apr. 25, May 2, 1981	Diagnostic & Therapeutic Skills in Internal Med. U of So. Calif Sch of Med., 2025 Zonal Ave, L.A., CA. Held: Mauna Kea Beach Htl, Kamuela, HI. 5 days, 29 hrs. Cat. 1.
Apr. 25, May 2, 1981	Emergency Medicine, U of So. Calif Sch of Med. 2025 Zonal Ave., L.A., CA. Held: Royal Lahaina Resort, Maui, HI. 5 days, 29 hrs. Cat. 1.
Apr. 26, 1981	"Generic Drugs & Medical Care." Spons: Lederle Labs/Hawaii Medical Assoc. Held: 9 a.m.-4:30 p.m., Ilikai Htl., Honolulu. Contact: HMA Office, 320 Ward Ave., S 200, Honolulu, HI 96814 (808) 536-7702.
May 2, 9, 1981	Pathology. U of So. Calif Sch of Med., 2025 Zonal Ave, L.A., CA. Held: Mauna Kea Beach Hotel, Kamuela, HI. 5 days, 30 hrs. Cat. 1.
May 5, 10, 1981	Recent Advances in Surg: Emergency Surg Problems. White Mem Med Cntr. 1720 Brooklyn Ave, L.A., 90033. Cospons: Loma Linda U Sch of Med. Held: Ilikai Htl, Waikiki & Wailea Bch. Htl, Maui, HI. 24 hrs. Cat. 1.
May 9, 16, 1981	Management of the Surg. Patient, Stanford U Sch of Med., Stanford 94305. Held: Mauna Kea Bch Htl, Kamuela, HI 96743. 6 days, 25 hrs. Cat. 1.
May 18, 21, 1981	Hawaii CME Sem. Loma Linda U Sch of Med, Anderson & Barton Rds., Loma Linda, CA. 92350. Held: Mauna Kea Bch Htl, Kamuela, HI. 4 days, 16 hrs. Cat. 1.
May 18, 22, 1981	Med Oncology Review. Am Coll of Phys., 4200 Pine St. Philadelphia, PA 19104. Cospons: U of H Sch of Med. Held: Honolulu. Contact: CME, U of H, 1960 E-West Rd., Honolulu 96822, (808) 948-7457.
May 23, 30, 1981	Allergy & Immunology. U of Wash Cont Med Ed, SC-50, Seattle, Wash 98195. Cospons: Wash St. Med Assn. Held: Wailea Beach Htl, Maui, HI. 7 days, 49 Hrs. Cat. 1.
June 15, 18, 1981	The Samson Thoracic Surg. Soc. Held at Hyatt Htl., Maui. 15 hrs. Cat. 1. Contact: Samson. Western North American, 13 Elm St., Manchester, Mass 01944.
June 15, 24, 1981	Radiology of Bone & Joint Disease. SanDiego Radiology Res & Ed Found., Box 2305 La Jolla, CA 92038. Cospons: Am Coll of Radiology. Held: Kona Surf Resort Htl, Kona, HI
Oct. 12, 16, 1981	AMA Regional & Scientific Mtg/HMA Annual Mtg. Held: Ilikai Htl, Waikiki. Contact: AMA Dept. of Mtg. Serv.; 535 No. Dearborn St., Chicago, IL 60610.

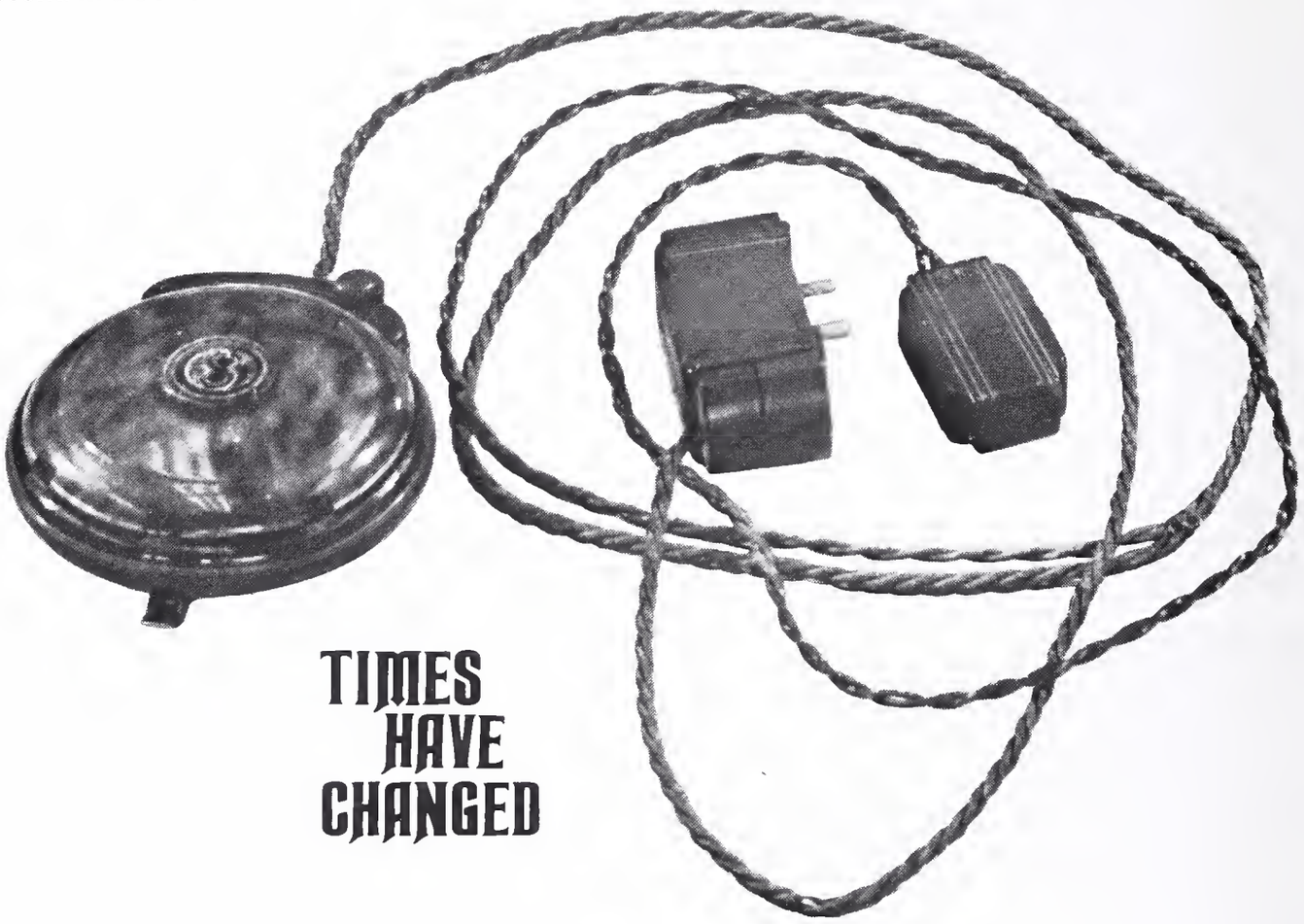
OUT OF STATE

For information on any out-of-state programs or courses, refer to September 3, 1980 Supplement to JAMA or call the HMA Office.



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Friday, February 6, 1981

HMA CONFERENCE ROOM

PRESENT:
Drs. Winn, Catts, Lum, Hindle, Bell, Chinn, Iaconetti, Fong, Wasson, Wentworth, Bade, Chun-Hoon, Shirasu, Bruce, Fong, Wigle, Mills, Fu, McNamee, Goto, Sia, Chang, Saiki, Dang, Bolian, Rogers, Mr. V. Thomas Rice, and Mrs. May Kim. HMA Staff present were: Messrs. Won, Jones, Leineweber; Mmes. Kendro, Chang, and Wong.

CALL TO ORDER:
The meeting was called to order by President Winn at 6:00 p.m.

MINUTES:
The minutes of the previous meeting were approved as circulated.

REPORT OF THE SECRETARY:
Council reviewed the Report of the Secretary as of January 31, 1981 which indicated that membership totaled 929 as compared with January 1980 when membership totaled 924. The comparison showed a decrease in active full dues-paying membership in all counties.

REPORT OF THE TREASURER:
The December 31, 1980 financial statement was reviewed in detail and filed subject to audit. Council expressed concern that HMA had exceeded its budget projections for 1980. Factors which contributed to the deficit were membership dues, Journal, PSRO, TV-Radio productions, and an adjustment to the pension plan. It was Council's general feeling that measures should be taken to keep expenditures within the budget for 1981.

Treasurer, Dr. William Hindle, recommended that for payroll checks only, *one* authorized signature be required for authorization of payment and that such checks be processed through the check signer with the Executive Director's signature.

ACTION:
It was moved, seconded, and passed to approve the recommendation.

REPORTS OF COMMITTEES AND COMMISSIONS:

A. Interprofessional and Public Affairs

Dues Incentive Program—On behalf of the HCMS Membership Recruitment Committee, Dr. Philip McNamee presented a report on the dues incentive pilot program for 1980 in which members who recruited a new member were given a $100 credit towards 1981 dues (credit prorated $20 county, $30 state, and $50 AMA). Since the anticipated increase in membership under this pilot program did not materialize, the Committee recommended that the program be discontinued. Council noted that AMA had agreed to participate in this program for a period of one year and that the HMA Membership Benefits Committee has continued to promote the program.

ACTION:
It was moved, seconded, and passed to continue the membership recruitment dues incentive program until January 1982.

Council requested AMA Trustee, Dr. George Mills, to present an interim report to the AMA, with the recommendation that AMA consider extending its participation in the program until January 1982.

Publications: Dr. McNamee reported that the Publications Committee met in January to review the financial status of the Hawaii Medical Journal. For 1980, the Journal lost approximately $20,000 due primarily to a serious loss of national advertising, as well as printing costs which exceeded the budget. While HMA had contracted with a national advertising firm in May 1980, the total amount of national ads printed in 1980 as compared to 1979 represented a drop of 54%. In view of financial considerations, the Publications Committee recommended: (1) that the Hawaii Medical Journal be published quarterly beginning in April 1981 if advertising contracts will permit; (2) that the Council approve cancellation of the contract with United Media Associates immediately, with a 90-day required termination notice; and (3) that a part-time person be hired to work exclusively on the Journal with this individual being responsible for obtaining ads, setting up the Journal, investigating printing costs, etc. Council also reviewed a tentative table of contents for the 125th Anniversary commemorative issue of the Journal.

ACTION:
It was moved, seconded, and passed to discontinue publication of the Hawaii Medical Journal as soon as possible within the contractual commitments.

Membership Benefits: The Committee recommended that Council consider the publication of a physicians directory to include all physicians practicing in the State of Hawaii instead of restricting it to include HMA members only. The Committee suggested that such a directory would serve a more beneficial purpose to the general public. It was also recommended that non-members be assessed $10-20 for the inclusion of their photograph, specialty, board certification, and medical school in the directory; subsequently enabling the non-member to acquire a free copy. If approved, Council felt that HMA members should be identified.

ACTION:
It was moved, seconded, and passed to approve the publication of a physicians directory in 1982 pending financial evaluation by the Finance and Publications Committee. In an amendment to the motion, Council agreed to assess non-members $50 for a listing in the directory. There were six opposing votes.

Tel-Med: Council discussed the Association's involvement in the Tel-Med program. A recommendation was made to discontinue HMA's participation in the program.

ACTION:
It was moved, seconded, and passed to discontinue HMA's participation in the Tel-Med program as soon as feasible within commitments. There were four opposing votes.

B. Public Health: On behalf of the Cancer Committee and Substance Abuse Committee, Mrs. Kendro recommended that HMA support the concept of using marijuana for medical purposes, not only for cancer patients. The committees felt it timely to make this recommendation in light of recent announcements that Drs. Thomas Lau and Kevin Loh have received approval from NCI to head a project in Hawaii which would permit the distribution of marijuana pills for treatment of nausea and discomfort associated with cancer.

ACTION:
It was moved, seconded, and passed to support the concept of using marijuana for medical research purposes.

ACTION:
It was moved, seconded, and passed to reaffirm our previous position that HMA is opposed to the legalization of marijuana. There was one opposing vote.

C. Health Service and Care: Health Manpower Committee Chairman, Dr. George Bolian, presented for Council's information a report which summarized the results of HMA's manpower survey. The Committee noted that HMA may be asked to comment on the survey results and suggested a prepared statement be disseminated. It was noted that HCMS has invited HMA to report the results of the survey to the HCMS at the May membership meeting.

ACTION:
It was moved, seconded, and passed to take the following position with regard to the survey: There was one opposing vote.
"HMA acknowledges that a survey was done of all physicians in Hawaii with a 40% response, that most of the physicians responding perceive that there is an excess of physicians in Hawaii, and that responses regarding the class size at the UH School of Medicine and residency programs were so varied that they did not reflect any consensus."

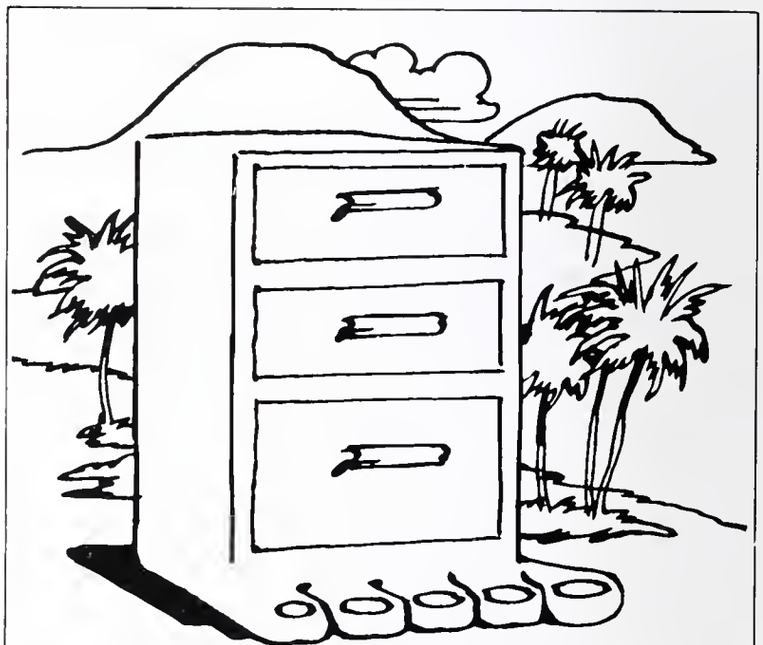
ACTION:
It was moved, seconded, and passed to make the survey results available to the HCMS and other counties in April; that background information on the survey be provided; and that those responsible for conducting the survey be present at the HCMS Membership Meeting when the survey is discussed.

Council reviewed an initial draft of a joint position statement regarding the Medical School which is under preparation by a joint committee of HMA and UH Medical School representatives. Council discussed the concept of the joint statement with Dean Terrence Rogers. It is anticipated that the statement will be finalized in the near future.

ACTION:
It was moved, seconded, and passed to support the general concepts as outlined in the draft joint statement.

ACTION:
It was moved, seconded, and passed to encourage continued dialogue between the HMA Health Manpower Committee and the UH Medical School, with periodic reports to both organizations.

D. Internal Affairs: President Winn reported that the Special Meeting of the House of Delegates has been scheduled for Saturday, May 2, 1981, from 1:30 p.m. to 5:30 p.m. at the Kapiolani-Children's Medical Center Auditorium. Due to the continuing interest in the issue of voluntary vs. mandatory AMA membership, Council agreed that proponents and opponents of the bylaws amendments each be given an opportunity to participate in the development of position papers. Those favoring unity will meet on March 2, and those favoring the voluntary approach will meet on March 9 at the HMA office. Both papers will be circulated to the membership along with a survey on the unit membership rule. At the May 2 meeting, any HMA member may present testimony on the issue. With regard to the proposed bylaws amendment concerning additional component societies, Dr. Winn reported that he has requested the Bureau of Research and Planning to develop possible guidelines for those areas which may wish to submit an application.



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E. EMS: EMS Chairman, Dr. Stanley Saiki, reported on the recent State Ethics Commission report which appears to criticize the HMA and DOH on its administration of the EMS Program. At this time legal counsel is reviewing the report which the EMS Program feels is unjustified. Council urged that EMS contract negotiations for the coming fiscal year be handled expeditiously.

F. Legislation: Dr. Douglas Bell reported that HMA has hosted a series of successful cocktail receptions for state legislators.

G. Building: Mr. Won reported that the Building Committee is currently exploring various mechanisms to refinance the building purchase. The Committee is awaiting response from Ward Estates regarding HMA's request to obtain an early renegotiation of the land lease. The Committee approved the revised budget for 1981.

H. Business/Medicine Coalition: Dr. Winn reported that the Business/Medicine Coalition held its second meeting. Business leaders expressed continued interest in disability problems, appeals mechanisms, and the CHIP program.

I. Jail Health Program: Dr. Walter Chang reported that the State Corrections Division would still like to pursue accreditation of its facilities under the Jail Health Care Program. Kauai's jail will serve as the model, and it is anticipated that this facility will be the first one accredited. Funding for the program after April 1981 is uncertain.

J. Medicaid: Dr. E. Lee Simmons reported that the DSSH has requested HMA's input for its Medicaid policy manual.



REPORTS OF COUNTY SOCIETY PRESIDENTS:

A. Honolulu: Dr. Henry Fong reported that HCMS held a successful membership meeting on February 3 on "Financial Planning for the 80's." A special membership meeting entitled, "Arthritis Update" is slated for February 10.

B. Maui: Dr. Eugene Wasson reported that Maui County held its last meeting on January 20 with Dr. William Dang as the guest speaker on the subject of emergency medical services. The Society also met with Xelan representatives. Maui County has just recruited eight new members under the dues incentive program, and the Society is in the process of incorporating.

OTHER BUSINESS:

A. Auxiliary: Mrs. May Kim reported that the Auxiliary's Council will be considering some important recommendations which have been formulated by the Long Range Planning Committee. The membership is also being surveyed regarding the Auxiliary's dues structure. AMA Trustee, Dr. George Mills, has been invited to speak at their next Council meeting.

B. Election: The Council unanimously elected Dr. Reginald Ho to serve as the University of Hawaii Medical School's representative on the Cancer Commission, for a three-year term ending in 1983.

C. Negotiations Seminar: Mr. Won reported that a successful negotiations seminar, "Dynamics of Conflict Resolution," was held in cooperation with the AMA on January 24-25, 1981. Thirty physicians and staff members attended the workshop.

D. Computer Seminar: Mr. Won announced that HMA will hold a special seminar on March 8 to address physicians' questions regarding computers in office practice.

ADJOURNMENT:

The meeting was adjourned at 9:55 p.m.

Hawaii Academy of Family Physicians' Newsletter

DON AND MARLIES FARRELL

Aloha to **new** resident affiliate **member John Rosemond Jr.,** a resident at Tripler AMC, who has transferred from the Uniformed Services chapter.

The following Active members were reelected to three year memberships after completing at least 150 hours CME in the past three years: **Mona Bomgaars, Thornton Dilcher, Fred Dodge, Kenneth Haling, Michael Padwick, Helen Percy, Edmund Schroeder, Marc Shlachter** and **Louis Polskin** . . . Congratulations!

The recent **HAFP Annual Seminar and Dinner Meeting** was judged a success by participants and organizers alike. AAFP president **Sam Nixon** installed **James Tsuji** as **president,** along with **Bob Todd, president-elect; Lily Ning, secretary; Don Farrell, treasurer; Tom Cahill** and **Don Farrell, delegates; Lincoln Luke** and **Jim Tsuji, alternate delegates;** and **new councilors John Aoki, Pat Walsh, Arch Wigle** and **Nate Wong.**

One of the highlights at the annual meeting was the presentation of a special award to **Dr. Edmund Ing** by **Fred Reppun,** as **Dr. Ing** was being honored for being in practice for fifty years. **Dr. Ing,** a Charter member of our chapter, was born and raised on Oahu, received most of his medical education in China and opened his general practice office in Honolulu in 1932. He has been married to **Audrey Dunseath** for 49 years and the couple have two sons and three grandchildren. **Dr. Ing** has been on the staff of all the major Honolulu hospitals and served as chief of staff at St. Francis in 1948. He is a member of HCMS and AMA and a member and fellow of the International College of Surgeons. He is one of the founders of the Hawaii chapter of AAFP and is now a life member as well as a fellow of AAFP. He still practices office medicine today. We congratulate **Dr. Ing** and wish him well!

In other **news of members** we hear that **Doris Jasinski** is closing her University Ave. office and selling the property. **Dr. Mergens** will take over **Ken Kern's** practice in April . . . **Don** and **Marlies Farrell** will attend the State Officer's Conference and Administrative Workshop in Kansas City in April.

CME News: The Georgia Academy is again offering a home study course "Infectious Diseases and the Primary Care Physician" beginning in May, acceptable for 50 hrs "P" credit. The fee is $295.00 for AAFP members, or $5.90 per credit hour. Enrollment deadline is April 20 and program begins May 18, 1981. Please contact: Georgia Academy of Family Physicians, Educational Foundation, Suite 235, 11 Corporate Square, Atlanta, Georgia 30329. Tel: 404-321-7445.





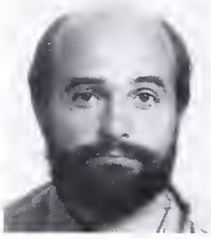
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NEUROLOGY

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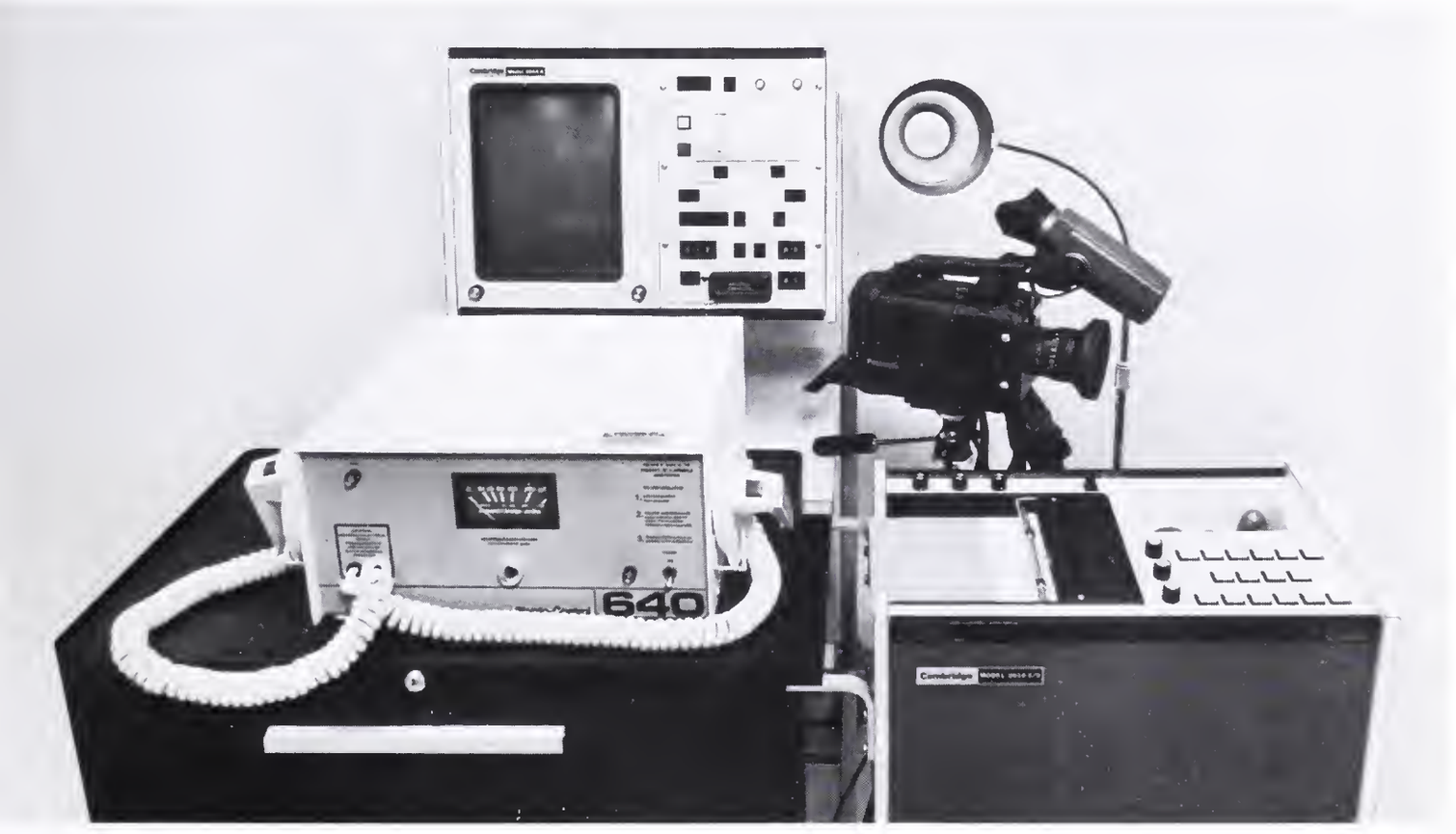
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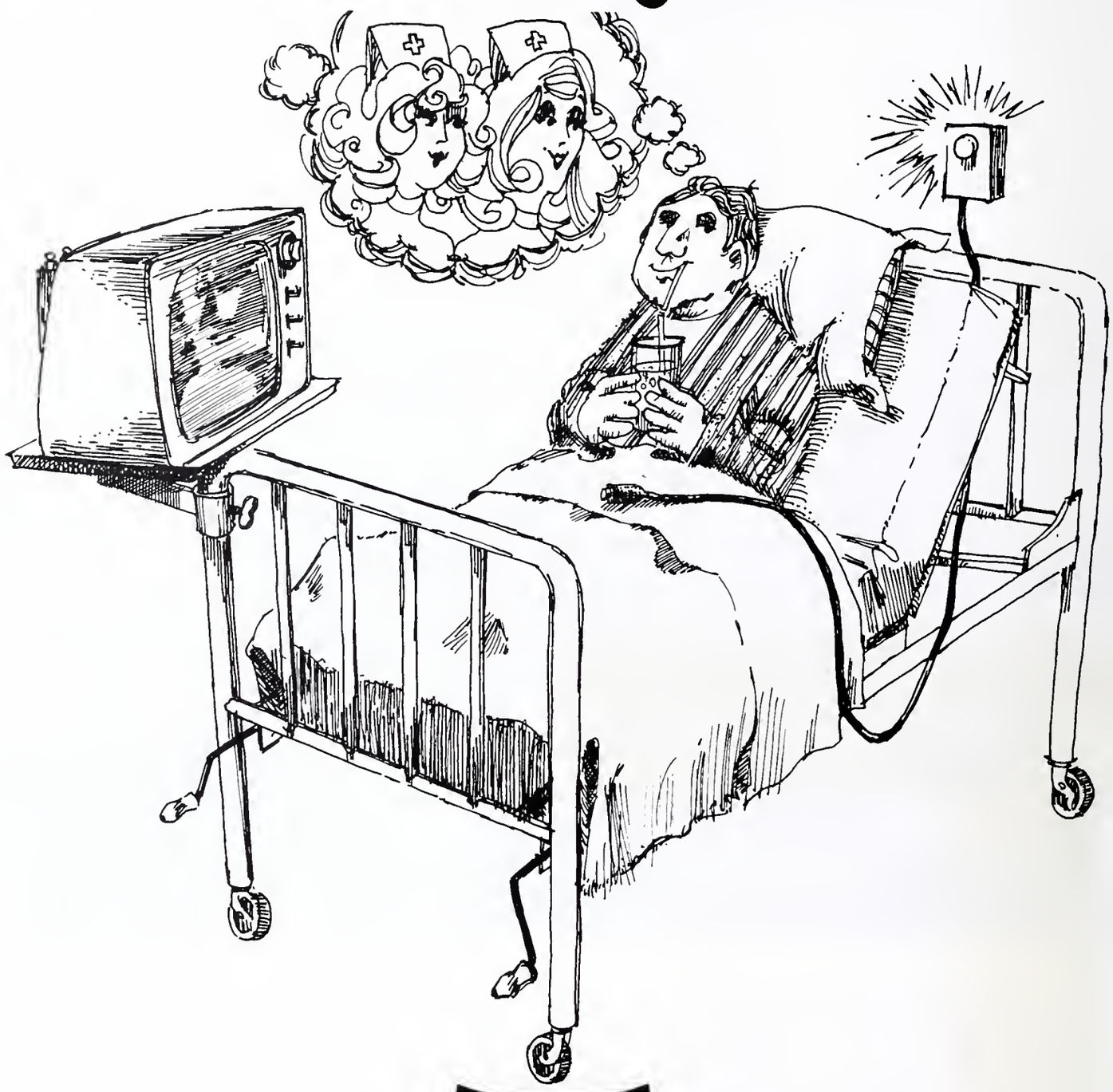
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APRIL 1981
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Feelings vs

Some people feel that I am misused and overused and that I'm prescribed too often and for too many kinds of problems.

The FACT is that approximately eight million people, or about 5 percent of the U.S. adult population, will use me during the current year. By contrast, the national health examination survey (1971-1975) found that 25 percent of the U.S. adult population experiences moderate to severe psychological distress. Additionally, studies of patient attitudes revealed that most patients have realistic views regarding the limitations of tranquilizers and a strong conservatism about their use, as evidenced by a general tendency to *de*crease intake over time. Finally, a six-year, large-scale, carefully conducted national survey showed that the great majority of physicians appropriately prescribe tranquilizers.

Some people feel that patients being treated with anxiolytic drugs are "weak," can't tolerate the anxieties of normal daily living, and should be able to resolve their problems on their own without the help of medication.

The FACT is that while most people can withstand normal, everyday anxieties, some people experience excessive and persistent levels of anxiety due to personal or clinical problems. An extensive national survey concluded that Americans who do use tranquilizers have substantial

Facts

justification as evidenced by their high levels of anxiety. It was further noted that antianxiety drugs are not usually prescribed for trivial, transient emotional problems.

Some people feel afraid of me because of the stories they've heard about my being harmful and having the potential to produce physical dependence.

The FACT is that there are thousands of references in the medical literature documenting my efficacy and safety. Extensive and painstakingly thorough studies of toxicological data conclude that I am one of the safest types of psychotropic drugs available. Moreover, I do not cause physical dependence if the recommended dosage and therapeutic regimen are followed under careful physician supervision. However, I can produce dependence if patients do not follow their physicians' directions and take me for prolonged periods, at dosages that exceed the therapeutic range. Patients for whom I have been prescribed should be cautious about their use of alcohol because an additive effect may result.

Many of the most knowledgable people feel that I became the No. 1 prescribed medication in America because no other tranquilizer has been proven more effective. Or safer.

The FACT is they are right.

For a brief summary of product information on Valium (diazepam/Roche) ℞, please see the following page. Valium is available as 2-mg, 5-mg and 10-mg scored tablets.

Valium® (IV)
diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy)
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults*: Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d., alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients*: 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children*: 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
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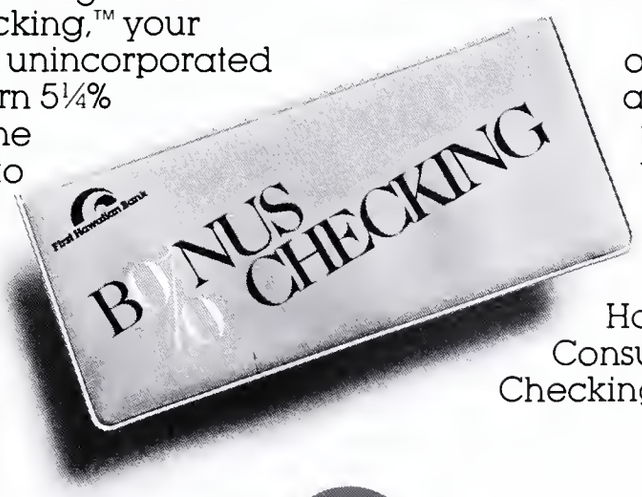


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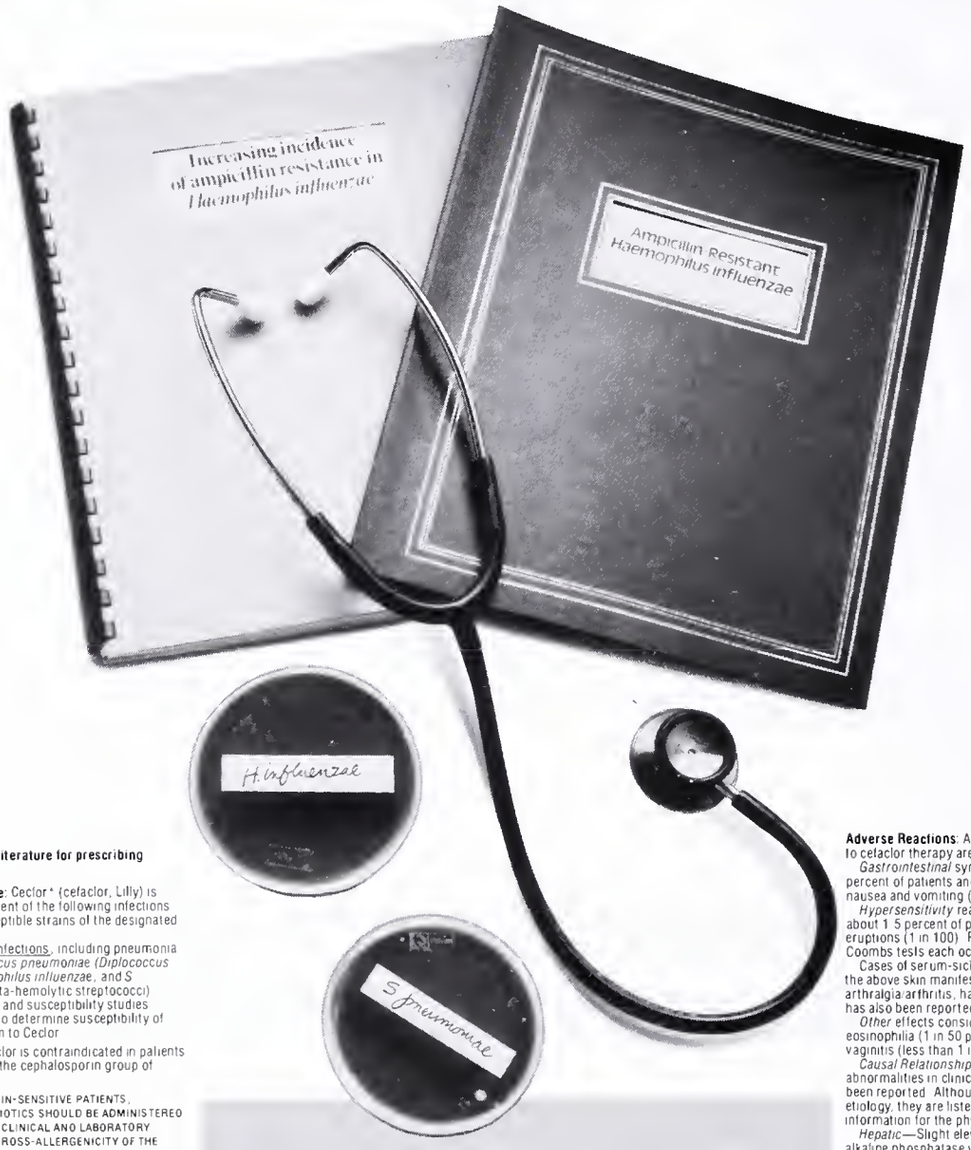
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An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

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Indications and Usage: Ceclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms.

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE)

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients.

Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported. Anaphylaxis has also been reported.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [103080R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S pneumoniae* or *H influenzae*.

Note: Ceclor* (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

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2 Antimicrob Agents Chemother, *11*:470, 1977
3 Antimicrob Agents Chemother, *13*:584, 1978
4 Antimicrob Agents Chemother, *12*:490, 1977
5 Current Chemotherapy (edited by W Siegenthaler and R Luthy), II 880 Washington, D C American Society for Microbiology, 1978
6 Antimicrob Agents Chemother, *13*:861, 1978
7 Data on file, Eli Lilly and Company
8 Principles and Practice of Infectious Diseases (edited by G L Mandell, R G Douglas, Jr, and J E Bennett), p 487 New York John Wiley & Sons, 1979

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

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Non-Fatal Shark Attack at Maui

KATHLEEN WELCH, M.D. *and* F.H. MARTINI, Ph.D., *Lahaina*

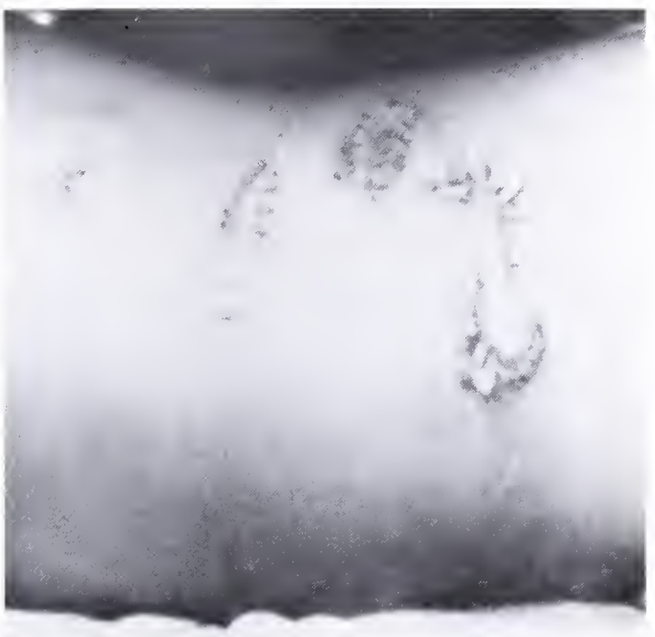
Considering the number of individuals exposed to the marine environment each year, shark attacks in Hawaiian waters are rare events. As of 1973, a total of only 31 such incidents could be verified as ever having occurred within the archipelago.[1] This report concerns a non-fatal attack which occurred off the southern limits of the town of Lahaina, Maui, August, 1980. It is instructive in that it presents features common to other attacks, both fatal and non-fatal.

The victim was an 18-year-old white man, 6′1″, 170 lbs, in excellent health. At the time of the attack, he was resting on a boogie board just outside of the surf line. It had been a dull, overcast day with occasional showers, and by 6 p.m. the lighting conditions were similar to twilight. The surrounding waters were extremely turbid, with visibility under 3 feet.

The shark struck the board and its rider from the left side, taking the board and a portion of the victim within its gape. As the jaws closed, the man was able to roll to his right into the water, opposite the shark. The presence of the board within its jaws prevented the animal from either making a second strike or obtaining a more substantial hold on its intended victim. With the board still held in its mouth, the shark pushed the victim through the water for a brief period before abandoning the attack. The swimmer reached the shore without assistance, and was taken to the Kaiser Clinic in Lahaina for treatment.

His injuries (Fig. 1) were confined to 4 horizontal and parallel lacerations, 2.5-5.0 cm apart. The lacerations were located on his left flank from the level of T_{12} to 3 cm below the iliac crest. The superior of these was a 2 cm linear laceration through the dermis to the subcutaneous tissues. The adjacent lacerations were skin flaps 4 cm long by 1.5 cm deep, ventrally based, into the deep dermis. These flaps were stretched to cover the dermal defects and tacked down at the edges.

FIG. 1.—*Left side of victim following treatment for lacerations received at the time of the attack.*



The 4th laceration, over the iliac crest, was 8 cm long, 4 cm wide, and 2-3 cm deep into the subcutaneous fat. The flap of skin remaining had a 1 cm pedicle. The flap was defatted, appeared viable, and was tacked down to the wound edges after several buried subcutaneous sutures brought the edges 2 cm closer. A Penrose drain was placed under this flap. Neither the muscle layer nor any vital organs were damaged, and bleeding was minimal. At the time of drain removal, 4 days later, the wound healing was satisfactory.

Discussion

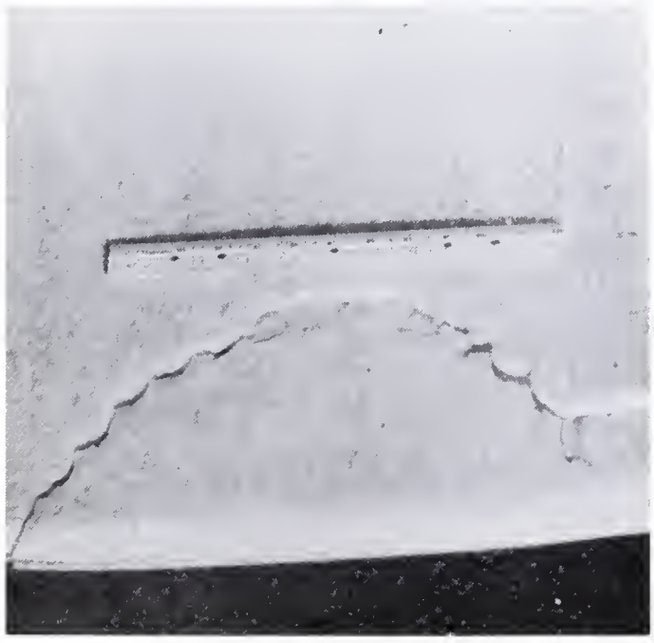
Usually, fewer than 100 shark attacks are reported each year worldwide. Less than half of these result in fatalities; the overall mortality averages 35%; in 1973 it was as low as 17%. A lack of adequate emergency care, hypovolemic shock, and drowning are major complications which in-

Kaiser Clinic, Lahaina, Hawaii 96761
Accepted for publication, September, 1980.

crease the severity of the incidents. The low mortality, despite the large size of the 'average' attacking animal (6′) supports the contention that the typical attack represents a territorial defense, rather than feeding behavior. Over 70% of the attacks analyzed in the Shark Attack File produced lacerations with no significant tissue loss; such wounds would be inflicted by a slashing movement of the cutting teeth for the upper jaw.[1] Almost 4 out of 5 of the attacks were confined to the extremities, and attacks were usually limited to 2 strikes or fewer (68% one contact only; 13% two contacts).[1] Such figures do not indicate that the typcial attack is a concerted feeding attempt by a large, highly efficient predator.

The attack on this Maui swimmer was not 'average' in terms of the wounds received. The lacerations were caused not by a slashing movement, but by a biting action involving both the upper and lower jaws, which left clear impressions in the boogie board (Fig. 2). Had the board not prevented a more substantial seizing of the victim, this attack would almost certainly have resulted in death. Removal of a 15″ crescent from the abdomen would have eviscerated him.

FIG. 2.—*Boogie board with bite section replaced; note serrated appearance of tooth marks.*



Because of the clear dental impressions left in the firm styrofoam of the boogie board, the attacking species could be positively identified; details of this analysis will be published separately.[2] The animal was a tiger shark, approximately 12.5′ long. Tiger sharks are worldwide in distribution, in tropical waters, and are the species second most often involved in attacks on humans. They are aggressive animals, pursuing active prey such as dolphins, turtles, and smaller sharks on an opportunistic basis. The animal shown in Fig. 3 is a tiger shark of the approximate size of the one in this attack. The dull coloration, broad head, short snout, wide jaws, and large curved teeth are characteristic of the species.

FIG. 3.—*This tiger shark* (Galeocerdo cuvier) *is approximately the size of the shark involved in the attack.*



Like many other sharks, tigers feed most actively from dusk to dawn and in turbid waters, coming closer to shore at these times. In addition, tiger sharks frequently feed at or near the surface. Thus the late hour, the dim light, and the turbidity of the water at the time of the attack were probably important. Secondary factors probably acted to encourage the attack. The victim's bathing suit, partially shredded in the attack, and the upper surface and lower skegs of the boogie board were international orange, a color known to be highly attractive to sharks. Finally, sharks had been reported (and ignored) in the area earlier that day, and sharks appear to act more aggressively when other sharks are close by. As this incident demonstrates that, despite the low probability of an attack occurring, appropriate preventive measures, ie, leaving the water, should be taken once sharks are seen.

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Eosinophils in Cerebrospinal Fluid: Criteria for Eosinophilic Meningitis

TIM KUBERSKI, M.D.,* *Honolulu*

• *Low numbers (1-6%) of eosinophils were observed in 9/123 consecutive cerebrospinal fluid (CSF) samples obtained from 110 pediatric patients with a variety of clinical diagnoses. A retrospective analysis of 8 hospitalized patients with eosinophils in the CSF suggested that high numbers (35-66%) of eosinophils in the CSF correlated best with clinical disease suggestive of* Angiostrongylus cantonensis *infection. It is suggested that an absolute count of 10 eosinophils or an eosinophilia of 10% of the total white cells in the CSF should be used as a minimum criterion for the diagnosis of eosinophilic meningitis.*

Few studies have been designed specifically to quantitate the number of eosinophils in the cerebrospinal fluid (CSF).[4] In reviewing cases of eosinophilic meningitis in Hawaii,[5] low numbers of eosinophils in the CSF were found not to correlate well with eosinophilic meningitis due to *Angiostrongylus cantonensis*, suggesting that low numbers of eosinophils in the CSF might more frequently be due to other causes. Since eosinophilic meningitis due to *A. cantonensis* is largely a clinical diagnosis, establishing laboratory criteria for eosinophils in the CSF might be helpful in making this diagnosis in patients with CSF eosinophilia. The objective of this study was to determine the frequency of eosinophils in routine examinations of CSF in a pediatric population, and to compare it to the CSF eosinophilia found in patients with eosinophilic meningitis due to *A. cantonensis*.

Methods

Between October, 1976, and January, 1977, all CSF specimens submitted to the clinical laboratory at Kauikeolani Children's Hospital (KCH) in Honolulu were examined for total cell count and differential determination of the cells present. The cells were enumerated using standard methods.[1] Two techniques were used for differentiating cells: microscopic examination of both a manually prepared Wright's-stained slide and a Wright's-stained preparation of cells sedimented by a cytocentrifuge (Shandon-Elliott Cytospin, Shandon Southern Instruments Limited, Frimley Road, Camberley Surrey, England). Samples grossly contaminated with blood were not included. Cell differentiation was done independently by me and another observer. A total of 200 cells were counted when sufficient cells were present. There was no observer discrepancy in the number of specimens containing eosinophils, although there were differences in the percentage of eosinophils observed. The reported percent eosinophils was obtained by averaging the readings.

The records of all patients with a discharge diagnosis of eosinophilic meningitis between 1961 and 1976 were reviewed. Certain features of these patients have been previously reported.[2,3,5]

Results

Of a total of 123 consecutive CSF samples from 110 patients examined, 9 patients (7%) had CSF specimens which contained eosinophils ranging from 1 to 6% of the total white cells. Of the 9, 2 were from CSF specimens containing numerous erythrocytes (one from a patient with a subdural hematoma, the other birth trauma). In 6 of the 9 specimens, eosinophils were not detected using the manual slide preparation of CSF. However, in those 6 specimens, less than 2% eosinophils were found using the cytocentrifuge method. Cell recognition and characterization was generally easier when examining slides of cytocentrifuged CSF.

The clinical diagnoses and percent eosinophils in the CSF from the 9 patients were subdural hematoma (1%), birth trauma (2%), sepsis (1%), near sudden infant death syndrome (1%), 2 patients with hydrocephalus and ventriculo-peritoneal shunts (1%), 2 patients with aseptic meningitis (2% and 3%) and one

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patient with erythroblastosis fetalis (6%). No patient had clinical signs and symptoms which suggested infection with *A. cantonensis*. None of these patients had a peripheral eosinophilia of more than 3%.

A total of 8 patients with a diagnosis of eosinophilic meningitis were admitted to KCH between 1961 and 1976. Of these, 7 had clinical disease that was consistent with eosinophilic meningitis due to *A. cantonensis*. The CSF eosinophilia ranged from 35 to 66 percent, and the total CSF white cell counts ranged from 262 to 2800/cmm. The 8th patient was a 9 year-old girl who had 10 eosinophils out of a total of 171 CSF white cells (6%). This patient may have had concomitant eosinophilic meningitis due to *A. cantonensis*, but clinically she had an aseptic meningitis associated with serologic evidence of mumps infection. The 8 patients had a mean peripheral eosinophil count of 10%.

Discussion

In a study of 1365 random CSF specimens, Sayk[8] reported an eosinophil count of 10% or greater in 2.4% of specimens. Olischer and Sayk[6] found 5 of 217 (2.3%) patients with meningitis to have a CSF eosinophilia of up to 80%. A 7% frequency of eosinophils in routine CSF examinations was found in this study of a pediatric population. However, the percentage of eosinophils was small, ranging from only 1 to 6%. Hawaii is an endemic area for *A. cantonensis*, and typical cases of eosinophilic meningitis have been diagnosed in this hospital population.[2,3,5] During the present prospective study of CSF, however, no clinically apparent *A. cantonensis* infections were observed.

Because CSF eosinophil counts of less than 10% can be found in a variety of clinical situations, small numbers of eosinophils in the CSF have limited diagnostic value. In a study of 484 cases of eosinophilic meningitis, about 95% of patients were found to have 10% or more eosinophils in the initial CSF examination.[7] In only 5% of those patients was the total CSF cell count less than 100 white cells/cmm. An absolute count of 10 eosinophils/cmm. or a 10% eosinophilia in the CSF containing more than 100 cells/cmm. has been used as criteria for eosinophilic meningitis due to *A. cantonensis*.[5] These criteria might be established to define a patient with the syndrome of eosinophilic meningitis, whether it is caused by *A. cantonensis* or other agents known to cause eosinophils in the CSF.[4]

Large numbers of eosinophils in the CSF are generally the hallmark of eosinophilic meningitis due to *A. cantonensis*. Until accurate serological tests become available, criteria should be developed so that this disease (and others causing CSF eosinophilia) can be separated from the seemingly large numbers of situations in which small numbers of eosinophils may be observed in the CSF.

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Monitoring Methenamine Therapy: Data From a Geriatric Population

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• *Pharmacy involvement in skilled nursing facilities is mandated by law.*[1] *One requirement is the monthly review of each patient's drug regimen by the pharmacist consultant. Although the method in which the reviews are to be carried out is not precisely defined, in general, attention is focused on ensuring that medication orders are properly recorded and implemented in accordance with established policies and procedures, and that there is evidence the existing drug therapy is being monitored for both effectiveness and safety.*

A drug frequently encountered in long-term care settings is methenamine.[2,3,4] It is employed in the form of its mandelate and hippurate salts and known widely by the established tradenames of Mandelamine®, Hiprex®, and Urex®. Because of certain advantages, it has been widely used for its urinary antiseptic properties for almost 100 years. These advantages include a low incidence of toxicity, freedom from development of bacterial resistance,[5] the absence of effect on normal bowel flora, and coverage of all urinary tract pathogens.[5,6] Literature reviews document methenamine's long history of development.[7,8]

This report will examine a monitoring parameter, urinary pH, used in assessing methenamine therapy in long-term care. In addition, it will take a retrospective look at 12 cases in which the pharmacist consultant intervened to suggest an order for a urine pH. The outcome of that intervention and some related issues will be discussed.

Significance of Urinary pH

The antimicrobial activity of methenamine depends on its conversion in the urine to formaldehyde. The generation of formaldehyde is a function of urinary pH, the concentration of methenamine and the duration that urine is retained in the bladder.[7,9,10] Peak concentrations of formaldehyde are achieved in the urine at a pH of 5.6. Detectable quantities are not produced when the pH reaches 7.[9] Effective concentrations on formaldehyde, 25 micrograms/ml. in a urine pH range of 5.7-5.85, must persist in the urine for a minimum of 2 hours to allow maximum bacteriostasis.[9,10]

These relatively recent findings support the classic observations of Hinman[11] and Shohl and Deming,[12] who suggested that methenamine should be administered with reduced fluid intake in order to: (1) reduce urine volume, thereby increasing methenamine concentration; (2) enhance acidification, thus increasing formaldehyde concentration; and (3) reduce the frequency of voiding, thus increasing the time period for interaction between bacteria and formaldehyde.

Survey Population

The 12 cases presented are extracted from the pharmacist consultant's drug regimen reviews performed during the months of May through August, 1979, at 2 long-term care facilities in Honolulu. The cases are selected on the bases of 2 criteria only: (1) receiving methenamine therapy and (2) the absence of a urine pH in the patient's medical record within the most recent 12 months. Factors such as age, sex, diagnoses and dietary considerations are excluded.

Results

Table 1 summarizes the results. In 8 of the 12 cases, urine pH's were ordered subsequent to the pharmacist consultant's suggestion. The pH values fall out of the range of effectiveness for methenamine in 2 patients (#1 and #4). Ascorbic acid was given to 6 patients (50%) to aid in urine acidification in a dosage range of 0.4-3.0 Grams/day. In-dwelling catheters were used in 5 patients (42%).

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TABLE 1.—*Characteristics of patients for whom urine pH's were suggested by the pharmacist consultant*

N=12	1	2	3	4	5	6	7	8	9	10	11	12
methenamine dosage (Grams/day)	4	4	4	2*	2*	4	2*	4	4	4	4	2*
urine pH ordered?	yes	yes	yes	yes	no	no	yes	yes	yes	no	no	yes
urine pH	7.0	5.0	6.0	6.5			6.0	6.0	6.0			6.0
ascorbic acid?	no	no	yes	yes	no	yes	no	no	yes	no	yes	yes
Grams/day			3.0	0.4		1.0			2.0		2.0	1.5
indwelling catheter?	no	no	yes	yes	no	yes	no	no	no	yes	yes	no

* hippurate salt; all others are the mandelate.

Discussion

The objective of monitoring methenamine therapy is to determine if urinary concentrations of formaldehyde are in a range that ensures antimicrobial efficacy. When the urinary pH escapes this range, not only is the drug therapy irrational but a waste of money. Table 2 lists the most common dosage forms and trade-names of methenamine and their wholesale cost to the pharmacist, before mark-up, at the recommended dosage for 1 year. Generic prescribing can cut the cost if pharmacists pass on the savings to the patients.

TABLE 2.—*Wholesale cost* to the pharmacist for methenamine mandelate (Mandelamine®) and methenamine hippurate (Hiprex® or Urex®) per year at recommended adult dose*

METHENAMINE MANDELATE	
dose: 1.0 Gm. q.i.d.	
0.5 Gm. tablets**	$181.04
1.0 Gm. tablets**	144.54
1.0 Gm. granules	363.39
0.5 Gm./5 ml. suspension**	607.77
METHENAMINE HIPPURATE	
dose: 1.0 Gm. b.i.d.	
1.0 Gm. tablets	135.78

* Actual cost to the patient subject to variations in markup
**Available as a generic

In our survey, 2 of 8 patients (25%) who had urine pH's ordered by their physicians were out of the therapeutic range (>6). Of the 2, patient #1 (pH=7.0) had the drug discontinued and was started on nitrofurantoin. Patient #4 continued to receive methenamine therapy.

It should be mentioned that isolated urine pH determinations cannot be relied upon as a basis for judging the constancy and degree of urinary acidification, but must be viewed as a guide.[13] If it is suspected that the urine pH is negating the methenamine therapy, serial urine pH determinations with Nitrazine paper is a simple and cost-effective measure to use. A nurse can read the results, obviating the necessity for ordering the more expensive urinalysis. Over a span of days or weeks, a good impression of the patient's urine pH pattern can be established accounting for such variables as diet or other drug therapy.

The practice of administering ascorbic acid to acidify the urine was first proposed by McDonald and Murphy in 1959.[14] Since then it has been supported and accepted as an effective adjunct to methenamine therapy,[15,16] largely on faith than on well-controlled studies. The gap in objective data is being filled by studies of more recent vintage that seem to offer a somewhat contradictory message.

In a study of 73 elderly patients receiving methenamine and ascorbic acid, Naccarto, Bell and Lamy found no significant relationships between urinary pH, the dosage forms of ascorbic acid, the salt of methenamine used, or the duration of methenamine therapy.[4] A study by Nahata *et al* on a small group of volunteers showed only a small average decrease in urinary pH with ascorbic acid dosages of 4.0-6.0 Grams daily; they concluded that ascorbic acid could not be relied upon to acidify urine.[17] At a daily dosage of 4.0 Grams daily, Vainrub and Musher discovered no urinary acidification, concluding that substantially higher doses may have a lasting effect on urine pH but at the expense of producing metabolic acidosis.[18]

The data in Table 1 can neither confirm nor refute the effectiveness of ascorbic acid in lowering urine pH. The dosages vary a great deal and are conservative, perhaps allowing for the advanced ages of the patients. However, the dosages of methenamine in both the mandelate and hippurate salts are the recommended adult doses, so it is most probable that the physicians were uncertain of their dosing, and judging from the lack of urine pH determinations in the medical record, not very curious as to the efficacy or necessity of ascorbic acid therapy.

In this era of increasing cost-containment measures and rational prescribing, it is appropriate to reconsider the habit of concurrently prescribing ascorbic acid with methenamine, unless the urine pH is established as alkaline prior to initiation of therapy. Should addition of ascorbic acid to the regimen be necessary, a responsibility follows to test the urine pH and adjust the dosage until effectiveness is assured. This may prove difficult as there is no dosage for ascorbic acid established to acidify urine. If increasing doses fail to correct alkaline urine, al-

ternatives to methenamine therapy must be considered.

Of the 12 patients in the survey, 5 had indwelling Foley catheters. Suppressant drug therapy is often indicated because in-dwelling urinary catheters are a leading cause of nosocomial urinary tract infection and a common predisposing factor in fatal gram-negative sepsis in hospitals.[19] The rationale for using methenamine in these cases has come under question.[18,20] Not only do data not support its use, but an understanding of the mechanism of action of methenamine suggests that this drug would be ineffective; it takes 30-90 minutes to produce inhibitory concentrations of formaldehyde even in an acid medium.[9,10] Since catheterization precludes the presence of residual urine, the opportunity for formaldehyde formation is minimal.

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The Most Successful Doctor

A recent study indicated that the most successful physicians are those who answer five questions, directly or indirectly, when confronting all but the most minor medical problems:

1) What is wrong? 2) What caused it? 3) What should be done about it? 4) What will it cost? 5) How long will it take?

A recurring major complaint of patients is that they don't get their questions answered. How about your patients, doc? How would they rate you and your staff on answering those questions today?

If you think you're "too busy" for all that talk, remember that information provided by aides, pamphlets, audiovisual material or Tel-Med counts, too. Some offices are even hiring "talkers" or counselors whose job is merely to *explain* things to the patient, and these helpers have proven tremendously cost-effective.

Efforts at improving our communication can help us fulfill Trudeau's admonition:

"To cure sometimes,
To relieve often,
To comfort always."

Oh! Don't overlook the final question those Most Successful Physicians asked: "Is there anything else you'd like to know?"

J.M.C.

The Unit Rule

Over twenty years ago, the British Medical Association was told by the Government that doctors would have to join it so that it could act as a labor union to negotiate fees for doctors employed by hospitals. The Association went to court to prevent compulsory membership from being instituted—and won. Membership in the B.M.A. remained voluntary.

Membership in the A.M.A. has always been voluntary, except for the requirement of some hospitals—none, any longer, in Hawaii—that medical society membership be required as a condition of staff membership.

Compulsory A.M.A membership, as a requirement for all physicians joining their state medical society (through county society membership), has existed for a good many years in about a dozen states—including Hawaii. All but four of those states (including Hawaii) have abandoned it within the past few years.

We still require county medical society members to belong to the State Association as well, and to join, and pay dues to, the A.M.A. This has been called the "Unit Rule," and of course the A.M.A. likes it. Our members do not like it; the compulsory feature alienates many, who have resigned in protest, and the extra cost alienates some, who have given up county society membership rather than pay the additional dues.

Polls of the membership on two or three occasions have made it clear that even the remaining members disapprove of being compelled to join the A.M.A. Many of these would voluntarily retain their A.M.A. membership if they were not so compelled; some, perhaps, would not.

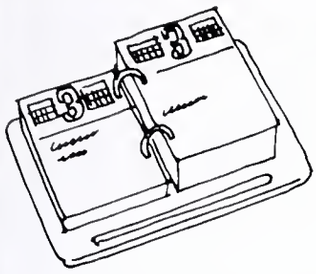
The House of Delegates, however, which has the power to make the decision, has on three occasions upheld the Unit Rule in spite of these polls.

We believe it is time to call a halt to the Unit Rule; to make A.M.A. membership voluntary. We believe every conscientious physician has an obligation to do his best in behalf of the public health and the public weal by belonging to organized medicine at both the state and national levels; a strong medical organization at both levels is vitally important to both our government and our own personal interests as physicians. No-one has a moral right to "take a free ride" by staying aloof from either the state association or the A.M.A.

Nevertheless, it is the duty of the House of Delegates of the Hawaii Medical Association to respond to the expressed desire of a substantial majority of its members, and abandon the Unit Rule. It would be well for members to attend the Reference Committee meeting and express themselves on this subject; we hope many who oppose the Unit Rule will heed this suggestion and turn out.

I have served long enough in the A.M.A. House of Delegates—6 years as a delegate from Hawaii, and 12 as either alternate or delegate from my specialty section—to know that while the A.M.A. will not rejoice at our departure from the fold, neither will it be damaged by it. They will lose a few members, and probably gain a few. We will join the large majority of states who have rejected compulsory A.M.A. membership for their state society members. We'll be in good company if we do so.

H.L.A.Jr



Continuing Medical Education

CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, First Thursday, 12:45 p.m. and Fourth Tues. 12:30 p.m. w/Maui Mem. Hsp. Held on Oahu at Am. Cancer Society main conf. room, 200 N. Vineyard, Honolulu.

John A. Burns School of Medicine

1. Dept of Medicine
 A. Case Conferences, Second and Fourth Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 B. Grand Rounds, First and Third Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 C. Endocrinology Grand Rounds, Third Wednesdays, 5:30-6:30 p.m., Queens University Tower, Room 506.
 D. Hematology Grand Rounds, Second and Fourth Mondays, 12:30-1:30 p.m., Queens University Tower, Room 721.
 E. Cardiology Grand Rounds, First and Third Tuesdays, 5:30-6:30 p.m., Queens University Tower, Room 508.
 F. Infectious Disease Grand Rounds, Second and Fourth Tuesdays, 5:00-6:00 p.m., Queens Nalani I Conference Room.
 G. Dermatology Grand Rounds, Second Wednesday, 7:30-8:30 a.m. Queens, Queen Emma Clinic.
 H. Pulmonary Grand Rounds, Second and Fourth Thursdays, 4:30-5:30 p.m., Queens Kamehameha Auditorium.
2. Division of Nuclear Medicine
 A. Technical aspects of Nuclear Medicine, Second Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506, 1½ credits.
 B. Rounds, Fourth Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506.
3. Dept. of Obstetrics and Gynecology
 A. Grand Rounds, Wednesday 7:30-8:30 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
4. Division of Orthopaedics
 A. Fracture Conference, Tuesdays, 5:00-6:00 p.m., Queens University Tower, Room 618.
 B. Shriners Hospital Conference, Tuesdays, 7:15-9:15 a.m., Shriners Hospital.
5. Dept. of Pediatrics
 A. Grand Rounds, Thursdays 8:00-9:00 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 B. Pediatric Conference, Mondays 12:45-1:45 p.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 C. Pediatric Infectious Disease Conference, Thursdays, 12:30-1:30 p.m., Kapiolani-Children's Medical Center, Third Floor Conference Room.
 D. Neonatal Ground Rounds, Fridays, 8-9:00 a.m., Kapiolani-Children's Medical Center, Administrative Conference Room.
6. Dept. of Psychiatry
 A. Grand Rounds, Fridays 8:00-9:30 a.m., Queens University Tower, Room 618.
7. Dept. of Surgery
 A. Grand Rounds, First, Second and Third Saturdays, 7:30-9:00 a.m., rotating hospitals.
 B. Statistical M and M, last Saturday, 7:30-9:00 a.m., rotating hospitals.
 C. Journal Club, First and Third Tuesdays, 6:00-8:00 p.m., Queens University Tower, Room 620.
 D. Medical-Surgical G.I. Rounds, Second Tuesday, 7:00-8:00 a.m., Queens University Tower, Room 506.
8. Depart of Family Practice
 A. Conf., Wednesdays, 8-9:00 a.m. Kaiser 4th Floor Conf. Room.
 B. Conf., Thursdays, 12-1:00 p.m. Kaiser 4th Floor Conf. Room.
9. Department of Physiology
 A. Dept. Conf., Wednesday, 4:30-5:30 p.m. BioMed T-210.
10. University of Hawaii, John A. Burns School of Medicine Grand Rounds, Third Thursday, 4:30-6:00 p.m., Queen's University Tower, Room 618 or BioMed Building.
11. HI Oncology Group, one Monday a mnth., 12:30-1:30 p.m., The Cancer Center, 1236 Lauhala St., 4th Floor Conference Room.

Federation of Emergency Medicine-Maui

1. **Cardiology for the Emergency Physician.** Every Monday, 9-10:00 a.m.-Maui Memorial Hsp. Conf. Rm #1. (For spec. topics or further info. contact: Federation Office (808) 244-7629, or Dr. C. T. Mitchell, (808) 244-9056.
2. **Journal Club in Emerg. Medicine.** 2 hrs. Cat. I. MMH Conf. Rm. #1. 9am-11 a.m.
 5/25/81 Annals of Em Med, 1/81; Abstracts in EM 2/81 - P. McCallum
 6/22/81 Annals of Em Med, 2/81; Abstracts in EM 3/81 - J. Mills
 7/20/81 Annals in Em Med, 3/81; Abstracts in EM 4/81 - C. Mitchell
 8/24/81 Annals in Em Med, 4/81; Abstracts in EM 5/81 - D. King

Hawaii Thoracic Society

1. Pulmonary Med., Clinical case presentations & current research in pul. med. with U of H Sinclair Chest Club. Third or Fourth Wed., ea month, 7:30 p.m.-9:30 p.m. For further info contact: Rosemary Respicio, B.S.N. at (808) 537-5966.

Hickam Clinic

1. Clinical Correlation Conference, First Thursday, 11:00 a.m.
2. Didactic—our staff, Second Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, Third Thursday, 11:00 a.m.
4. Radiology Conference, Fourth Thursday, 11:00 a.m. (Contact Aurora Macapinlac, M.D., M.C., 449-5770)

THE QUALITY OF OUR WORLD IS RELATIVE TO THE PERSPECTIVE FROM WHICH WE VIEW IT. For a select few, a majestic perspective on Oahu's south shore is now being offered in exclusive fee simple homesites at Hawaii Loa Ridge. Each site has been shaped to provide sweeping views of the ocean, Diamond Head, Molokai and Koko Head. There will be an opportunity here to live in an atmosphere of privacy and elegance just minutes from downtown Honolulu. It may be the last of its kind.

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Hilo Hospital

1. Orthopedic Conference, First Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, Second Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, Third Friday, 12:30-1:30 p.m.
5. C.P.C., Second Friday, 12:30-1:30 p.m.
6. Visiting Professor's Program

Kaiser Hospital

1. Medicine Grnd. Rnds. Every Tues. 8 a.m. Pac. Aud. 1 hr. Cat. 1.
2. Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. 1.
3. OB/Ped. Perinatal Mortality Conf. Last Tues. ea. mnth. 8:00 a.m. 1 hr. Cat. 1.
4. Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. I.
5. Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. 1.

(Contact CME Dept.-Kaiser for further information)

Kapiolani-Children's Medical Center

1. Pediatric Grnd. Rnds. Every Thursday, 8-9:00 a.m. Aud.
2. Pediatric Conf. Mondays, 12:45-1:45 p.m. 2nd Floor Aud.
3. Neonatal Grnd. Rnds., Fri. 8-9:00 a.m., Conf. Rm. B.
4. Pediatric Infectious Disease Conf., Thursdays, 12:30-1:30 p.m. 3rd Floor Conf. Rm.
5. Ob-Gyn Conf. Tues. 1-2:00 p.m. Aud.
 First—Didactic Presentation
 Second—Perinatal-Neonatal Topics
 Third—Obstetrics Topics
 Fourth—Gyn Topics
6. Tumor Brd.—Oncology Conf. First and Third Fri. 1-2:00 p.m., Aud.

Kuakini Medical Center

1. Department of Ophthalmology Meeting, First Tuesday, 12:30-1:30 p.m.
2. G. I. Conference, First Tuesday, 8:00-9:00 a.m.
3. Department of Medicine Meeting (Statistical), Fourth Tuesday, 1:00-2:00 p.m.
4. Nephrology Conference, Second Wednesday, 8:00-9:00 a.m.
5. Oncology Conference, Every Thursday, 7:30-8:30 a.m.
6. Pulmonary Conference, First Thursday, 1:00-2:00 p.m.
7. Surgical Conference, First & Fourth Friday, 12:45-1:45 p.m.
8. Surgical Mortality & Morbidity Conf., Fifth Friday, 12:45-1:45 p.m.
9. Visiting Professors Programs
10. Internal Medicine Dept. Meeting—Evening, Second Tuesday, 6:00-7:00 p.m.

Maui Memorial Hospital

1. Thurs. Conf. 7-8:00 a.m. Staff Dining Rm.
 1st—Dept. of Medicine
 2nd—Dept. of Surgery
 3rd—Dept. of OB/GYN
 4th—Dept. of Pediatrics
 5th—Elective
2. Tumor Brd. every Mon. 12:15-1:15 p.m.—Tumor Conf. Telephone Task Force—Third Tues. 12:15-1:15 p.m.
3. Dept. of Emergency Med., Third Mon., 7-8:00 a.m.
4. Diagnostic Radiology—Fourth Tues., 12-1:00 p.m.
5. SFH-UH Hematology Conf., Third Thursday, 12:30 p.m.Sullivan-4 Classroom.
6. SFH-UH Surgical Grand Rounds, First, Second, & Third Fridays, 7:30 a.m., Sullivan-4 Classroom.
7. Visiting Professor Programs (for further info call CME office at St. Francis).

The Queen's Medical Center

1. ENT Conferences, First and Second Fridays, 7:30 a.m., Small Dining Room.
2. Medical Conferences, Every Friday, 8:00 a.m., Kam Auditorium.
3. Ob/Gyn Conferences, Second and Fourth Mondays, 1:00 p.m., Kam Auditorium.
4. Ophthalmology Conference, Fourth Tuesday, 5:00 p.m., Queen Emma Eye Clinic.
5. Orthopaedic Conferences, Every Wednesday, 7:00 a.m., Kam Auditorium.
6. Pathology Conferences, Every Wednesday, 7:30 a.m., Surgical Conference Room.
7. Pediatric Grand Rounds, Fourth Thursday, 12:30 p.m., Nalani 1 Conference Room.
8. Surgical Trauma Conference, Second Tuesday, 4:30 p.m., Kam Auditorium.

 Basic Science Lectures, Every Wednesday, 7:15 a.m., Queen's University Tower, Room 618.

St. Francis Hospital

1. SFH-UH Tumor Conf., Every Monday, 7:30 a.m. Sullivan-4 Classroom.
2. SFH-UH Nephrology Conf., First Monday, 1:00 p.m. Sullivan-4 Classroom.
3. SFH-UH Endocrine Conf., last Monday, 12:30 p.m. Sullivan-4 Classroom.
4. EENT Meeting, First Tuesday, 7:00 a.m., Sullivan-4 Classroom.
5. SFH-UH Hematology Conf., Third Thursday, 12:30 p.m. Sullivan-4 Classroom.
6. SFH-UH Surgical Grand Rounds, First, Second, & Third Fridays, 7:30 a.m., Sullivan-4 Classroom.
7. Visiting Professor Programs (for further infor call CME office at St. Francis).

Straub Clinic & Hospital

1. Straub Professional Seminar meets the Second Tuesday of each month, from 5:00-6:30 p.m. in the Credit Union Meeting Room (2nd Floor, Credit Union Bldg).
2. Surgical Mortality and Morbidity Conference meets every Fourth Thursday of each month, from 7:00-8:00 a.m. in the Doctors' Dining Room.
3. Cardiac Surgery Conference meets the Third Tuesday of each month, from 4:30-5:30 p.m. in the Doctors' Dining Room.
4. Department of Anesthesiology meets the Second Tuesday of each month from 7:00-8:00 p.m. in the Doctors' Dining Room.
5. Community Peripheral Vascular Conference meets the Fourth Thursday of each month from 5:00-6:30 p.m. in the Doctor's Dining Room.
6. Visiting Professor Program meets monthly from 7:00-8:00 a.m. in the Doctors' Dining Room.
7. Urology Inservice meets every other month on the Third Friday from 8:00-9:00 a.m. in the Doctors' Dining Room.
8. Neuropathology Clinical Correlation Conference meets the Third Thursday of each month from 7:30-8:30 a.m. in the Straub Morgue.
9. OB-GYN Pathology meets every Fourth Monday of each month from 12:30-1:30 p.m. in the Administration Conference Room (ACR).
10. Urologic Pathology meets every First Monday of each month from 8:00-9:00 a.m. in the Doctors' Dining Room.
11. Friday Noon Conference meets every Friday of each month from 12:30-1:30 p.m. in the Doctors' Dining Room.

*Note: All conferences are subject to change. Monthly calendar will be available upon request.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday

2. General Medical Staff Meeting—Second Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Miscellaneous

HMA Maternal and Perinatal Mortality Study Cmte. First Monday ea. month-5:30 p.m. 320 Ward Ave., S 200. Cat. I on hr. for hr. basis.

SPECIAL EVENTS

May 2, 9, 1981	Pathology. U of So. Calif Sch of Med., 2025 Zonal Ave, L.A., CA. Held: Manna Kea Beach Hotel, Kamuela, HI. 5 days, 30 hrs. Cat. I.
May 5, 10, 1981	Recent Advances in Surg: Emergency Surg Problems. White Mem Med Cntr. 1720 Brooklyn Ave, L.A., 90033. Cospons: Loma Linda U Sch of Med. Held: Ilikai Htl, Waikiki & Wailea Bch. Htl, Maui, HI. 24 hrs. Cat. I.
May 9, 16, 1981	Management of the Surg. Patient, Stanford U Sch of Med., Stanford 94305. Held: Mauna Kea Bch Htl, Kamuela, HI 96743. 6 days, 25 hrs. Cat. 1.
May 18, 21, 1981	Hawaii CME Sem. Loma Linda U Sch of Med, Anderson & Barton Rds., Loma Linda, CA. 92350. Held: Mauna Kea Bch Htl, Kamuela, HI. 4 days, 16 hrs. Cat. 1.
May 23, 30, 1981	Allergy & Immunology. U of Wash Cont Med Ed, SC-50, Seattle, Wash 98195. Cospons: Wash St. Med Assn. Held: Wailea Beach Htl, Maui, HI. 7 days, 49 Hrs. Cat. I.
June 15, 24, 1981	Radiology of Bone & Joint Disease. SanDiego Radiology Res & Ed Found., Box 2305 La Jolla, CA 92038. Cospons: Am Coll of Radiology. Held: Kona Surf Resort Htl, Kona, HI
June 24, 28, 1981	The Samson Thoracic Surg. Soc. Held at Hyatt Htl., Maui. 15 hrs. Cat. 1. Contact: Samson. Western North American 13 Elm St., Manchester, Mass 01944.
July 11, 18, 1981	Endoctrine Metabolic Crse., U of So. CA Schl of Med., 2025 Zonal Ave., LA, CA 90033. Held: Mauna Kea Beach Htl, Kamuela, HI.
July 22, 29, 1981	Refresher for Technologists & Pathology. U. of So. CA Schl of Med., 2025 Zonal Ave., LA, CA 90033. Held: Kauai Surf Htl, Kauai, Hi.
July 31, Aug 4, 1981	ACP Internal Medicine Update, Spons: ACP & J.A. Burns Schl of Med, Honolulu, Contact: Dee Chang (808) 947-8573 or 948-7457. Held: Wailea Beach Htl, Maui.
Aug 7, 8, 1981	Ophthalmology Annual Mtg., Alumni U of CA Irvine Coll. of Med., Irvine, CA. Held: Kona, HI.
Aug 26, Sept. 7, 1981	Third Ann. Radiology for Nonradiologists. San Diego Rad. Res. & Educ Found, Box 2305, LaJolla, CA. 92038; cospons: Am Col of Radiology. Held; Kauai Surf Resort Htl, Kauai. 35 hrs. Cat. 1.
Oct. 12, 16, 1981	AMA Regional & Scientific Mtg/HMA Annual Mtg. Held: Ilikai Htl, Waikiki. Contact: AMA Dept. of Mtg. Serv.; 535 No. Dearborn St., Chicago, IL 60610.

OUT OF STATE

For information on any out-of-state programs or courses, refer to September 3, 1980 Supplement to JAMA or call the HMA Office.

HAWAII MEDICAL ASSOCIATION 1856

HMA Council Meeting

Friday, March 6, 1981
HMA CONFERENCE ROOM

PRESENT:

Drs. Winn, Lum, Hindle, Bell, Chinn, Iaconetti, Fong, Wasson, Bade, Lumeng, Bruce, Cahill, Fong, Fu, Newman, Mills, Char, Goto, Chang, Dang, Arnold, Mr. V. Thomas Rice, and Mrs. May Kim. Guests present were: Dr. Kent Bennett, Tim Shiraki, and Elizabeth Dickson. Staff present were: Messrs. Won, Jones, Leineweber; Mmes. Kendro, Wong, and Chang.

CALL TO ORDER:

The meeting was called to order by President Winn at 6:10 p.m.

MINUTES:

The minutes of the previous meeting were approved as amended.

REPORT OF THE SECRETARY:

Council reviewed the Report of the Secretary as of February 28, 1981, which indicated that membership totaled 933 as compared with February 1980 when membership totaled 923.

REPORT OF THE TREASURER:

The January 31, 1981 financial statement was reviewed in detail and filed subject to audit.

REPORTS OF COMMITTEES AND COMMISSIONS:

A. Interprofessional and Public Affairs:

Publications—On behalf of the Publications Committee, Dr. Harry Arnold (Editor, HAWAII MEDICAL JOURNAL) appealed to Council to permit continued publication of the Journal until at least the June issue, to give the committee an opportunity to explore various avenues for increasing advertising revenue. The Committee reported plans to solicit Journal management proposals from advertising firms as well as to request support from members and past advertisers. Council noted letters in support of the Journal from Dr. Reppun and from the Hawaii Medical Library. Dr. Arnold encouraged physicians to donate funds to continue the Journal and personally pledged $1,000.

ACTION:

It was moved, seconded, and passed to con-

tinue publication of the HAWAII MEDICAL JOURNAL until at least June.

Health Fair: Mrs. Kendro noted that Council had earlier voted to send a physician consultant to the Health Fair's Advisory Committee. HMA had appointed Dr. Fred Gilbert as its representative, and the HCMS had appointed Dr. John Houk. The fair is scheduled for April 20-26, 1981, at various sites throughout the State, and physician volunteers are requested to assist in answering questions and making proper referrals to various health resources. The HCMS will also provide information on its referral service.

ACTION:

It was moved, seconded, and passed to solicit physician volunteers for the Health Fair.

Tel-Med: Council was informed that HMA's agreement with Tel-Med will run through December 1981.

B. Peer Review and Medical Education: Mr. Tom Rice presented a report from the Peer Review Committee regarding its deliberations on Resolution No. 3 (adopted by the 1980 House of Delegates) which proposes the creation of subcommittees of specialty societies under the umbrella of the HMA's Peer Review Committee. The Committee concluded that it would be extremely difficult to provide that these specialty society peer review committees come under the umbrella of the HMA. The Committee recommended that HMA should not pursue the issue at this time unless further information is received and at least until the statutes have been tested in court or ambiguities resolved by the legislative process. It was further recommended that the peer review committees of the HMA and HCMS obtain consultants from specialty societies via a formal request that they designate consultants to all of the appropriate HMA and HCMS peer review committees. Council discussed the possibility of seeking appropriate legislative amendments.

ACTION:

It was moved, seconded, and passed to refer this matter to the Peer Review Committee for further study.

C. Health Service and Care: Dr. Neal Winn presented for Council's approval, a revised draft joint statement of the HMA and the John A. Burns School of Medicine regarding the size of the medical school and residency training programs, which was just finalized by a joint subcommittee of the two organizations.

ACTION:

It was moved, seconded, and passed to adopt the joint statement. Council agreed that the joint statement be disseminated to the membership.

D. Legislation: Mr. Jon Won presented a status report on pending health legislation. Council was briefed on HMA's testimony in a number of areas including Medicaid, medical torts, compensation for medical claims conciliation panel, health planning and certificate of need, long term care, worker's compensation, controlled substances, child abuse and neglect, special education, etc. Council commended the members of the Legislative Committee for their dedicated efforts on behalf of the membership.

E. EMS: Dr. William Dang reported that the attorney for the EMS Program has sent a letter to the State Ethics Commission pointing out the improprieties of the Ethics Commission opinion and ending with a request that Opinion No. 416 be withdrawn. The attorney for EMS subsequently received a letter from the Executive Director of the Ethics Commission stating that EMS legal counsel's letter and the matter would be taken up by the Ethics Commission at its next meeting. Council also reviewed the HMA President's recent letters to the editor of the *Honolulu Advertiser* and the *Honolulu Star-Bulletin* regarding the Ethics Commission opinion.

F. Internal Affairs: It was suggested to use a registered parliamentarian for the Special Meeting of the House of Delegates on May 2.

G. Medical Services: Council discussed the feasibility of conducting a survey on physicians' incomes.

H. Jail Health Program: Mrs. Kendro reported that a resolution is being drafted for introduction at the Legislature in an effort to assist Kauai's jail in becoming accredited under AMA's accreditation standards.

I. Building: Dr. Neal Winn reported that a meeting was held with representatives of Ward Estates to open discussion regarding the renegotiation of the land lease. Council was informed that Ward Estates has agreed to let HMA submit a proposal for the renegotiation. The Building Committee submitted for Council's approval a proposed initial offer to Ward Estates covering a 30-year period with increased land lease rents on an incremental basis. The Committee also recommended that HMA limit pass through costs to tenants on HMA's incrementally increased land lease rent to 30¢ per square foot.



ACTION:

It was moved, seconded, and passed to approve the initial offer to Ward Estates.

ACTION:

It was moved, seconded, and passed to limit pass through costs on HMA's incrementally increased land lease rent to 30¢ per square foot increment.

REPORTS OF COUNTY SOCIETY PRESIDENTS:

A. Honolulu: Dr. Henry Fong reported that the Society's membership Meeting on March 3 featured a mock Medical Claims Conciliation Panel hearing and a presentation on the experience of the MCCP. HCMS will hold its next meeting on April 7 with a legislative update and discussion on the unit rule issue.

B. Maui: Dr. Eugene Wasson reported that Maui County Medical Society was incorporated on November 14, 1980. The Society held its last membership meeting on February 17 with a program on the clinical biology of cancer by guest speaker, Dr. Thomas Hall. Two new members were elected into the Society. Dr. Neal Winn and Jon Won will visit the Society on March 17.

C. Hawaii: Dr. Ernest Bade reported that Hawaii County met on February 26, at which time two new membership applications were approved. Guest speaker was Dr. John Sheedy, DSSH Medical Consultant, who discussed the socioeconomic aspects of Medicaid and monitoring by the program. The Society is attempting to develop a medical radio program.

OTHER BUSINESS:

A. Auxiliary: Mrs. May Kim reported that the HCMS Auxiliary held a successful wellness seminar on April 21. The Auxiliary Long Range Planning Committee has developed several important recommendations which will be considered at their annual convention in May. The proposed recommendations would affect Auxiliary membership on the state and national levels, as well as funding and fiscal policies.

ACTION:

It was moved, seconded, and passed to refer the recommendations of the Auxiliary's Long Range Planning Committee to the HMA Bureau of Research and Planning for study and report back to Council at its April meeting.

B. Request from Hawaii Lions Eye Bank & Makana Foundation: Dr. Kent Bennett and Mr. Tim Shiraki, representing the Hawaii Lions Eye Bank and Makana Foundation, requested the support of HMA for its organ donor registry, procurement, and distribution program. The Hawaii Lions Eye Bank program and Makana Foundation are scheduled to merge in the near future. The Lions will administer and underwrite the program. Dr. Bennett reported that the medical and surgical aspects of the program will be guided by a 40-member medical advisory committee. The Advisory Committee will establish guidelines to assure that standards of acceptability are met. Lions' representatives emphasized the need for support by the medical association and requested that the program be allowed to use the HMA logo for ads placed by the Hawaiian Lions Eye Bank and Makana Foundation in its drive to obtain more donors.

ACTION:

It was moved, seconded, and passed to support the concept of the Hawaii Lions Eye Bank and Makana Foundation program.

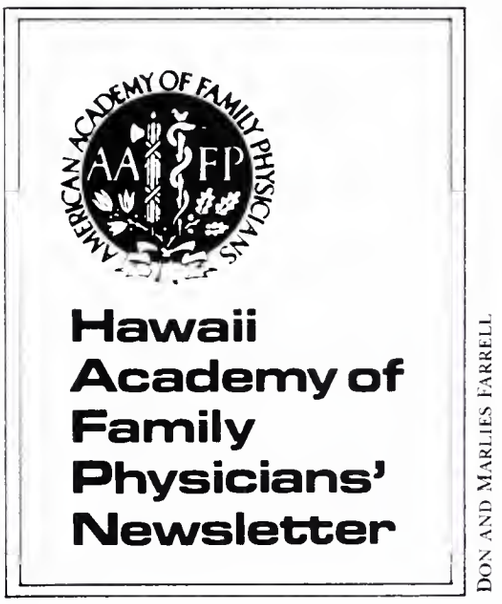
ACTION:

It was moved, seconded, and passed to permit the Executive Director to authorize the use of the HMA logo for specific ads placed by the Hawaii Lions Eye Bank and Makana Foundation in its drive to obtain more registered donors.

C. Computer Seminar: Mr. Jon Won announced that the computer seminar has been postponed to March 15. Computer consultant, Dennis Streveler, will serve on the faculty as a replacement for Robert McDowell.

ADJOURNMENT:

The meeting was adjourned at 9:45 p.m.



DON AND MARLIES FARRELL

We have no **new members** this month, however **Ernest Bade** and **Rod Miller** were reelected to three year Active memberships after having completed at least 150 hours of CME. Congratulations!

In other **news of members**: **Dave** and **Sala Gilmour** are the new parents of a baby-boy, their second child and first son . . . **Tom Cahill** is attending a meeting of the Mead Johnson Award Committee in North Carolina this month. **John Rosemond Jr.**, a Tripler resident, is this year's candidate for the award; Hawaii had a winner last year in **Harold Timboe**, also from Tripler . . . **Jim Koch** could hardly tear himself away from the ski slopes but has finally returned to Molokai . . . congratulations to the following members who became board certified during 1980: **Allen J. Chun, Robert Conrad, Darcel Gilbert** and **James Sandys.**

Recent **Council Actions:** Newly installed HAFP president **James Tsuji** appointed the following committee chairmen: Constitution and Bylaws—**J.I.F. Reppun;** Healthcare Services—**Lincoln Luke;** Education—**John Aoki** (replacing **Bob Todd** in June); Minority Affairs—**Nathan Wong;** Legislative Affairs—**Tom Cahill;** Membership—**Lloyd Kobayashi** and Finance—**Don Farrell.**

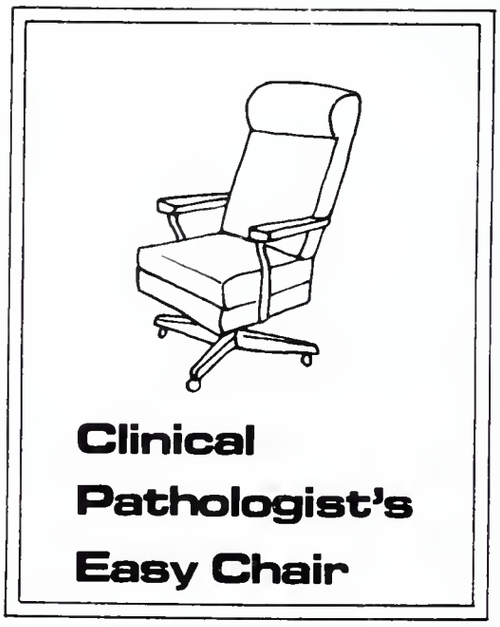
To aid recruiting Council voted to pay student members' first year dues.

Don Farrell reported that the U.H. Medical School is in need of preceptors for fourth year medical students. Approximately 20 members of our chapter have volunteered over the years to take students into their offices for a six week "learn-a-thon," showing

them what family Practice is all about. This is our chance to be role models and influence the career choices of the physicians of tomorrow. One of the comments heard from a preceptor: "They slow you up a little but challenge you a lot." Along the same lines, **Don Farrell** and **Jim Tsuji** will be taking part in career day for U.H. medical students on May 2nd and speak to them about our specialty. This will probably create an even greater need for preceptors, so if you are willing to volunteer yourself and your practice and be a preceptor, please contact **Dr. Frank Tabrah** at the Medical School at 948-8287.

Remember **Hawaii Review?** Our Canadian friends will soon be inviting all of us to a meeting in British Columbia. It will be held at a beautiful mountain resort outside Vancouver in early September. And the Canadians can't wait to get back to Honolulu for Hawaii Review II to be held in February 1983.

And it's not too early to start planning for the next AAFP Scientific Assembly in Las Vegas, Sept. 21 thru 24, 1981 and the post convention meeting in Kauai.

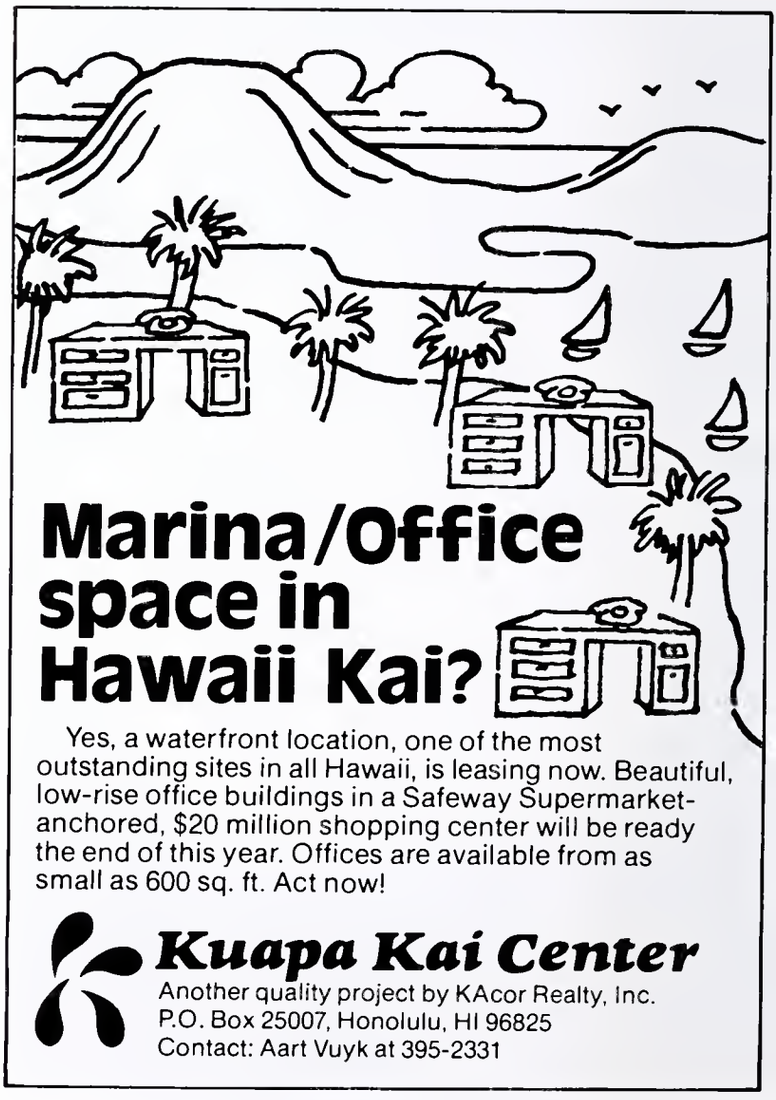


HDL-CHOLESTEROL

Coronary Heart Disease (CHD) develops in 20 to 25% of U.S. men by age 60 years, and about 75% of these patients have total cholesterol levels in the "normal" or usual range. The total cholesterol level is considered a fairly good risk factor in the younger individuals, but not with increased age. Epidemiologic studies have shown that the HDL-cholesterol is a better lipid predictor of CHD.[1] The higher the HDL-cholesterol, the lower the risk for CHD. Relatively high levels appear beneficial since they reduce the risk of developing CHD, in contrast to the increased risk with LDL-cholesterol. One theory of cholesterol metabolism is that LDL-cholesterol is deposited in the arterial wall and is removed by the HDL. This HDL-cholesterol is transported to the liver where it is metabolized to bile acids and excreted.

About 75% of the total cholesterol is in the LDL (low density lipoproteins), 15% in the HDL (high density lipoproteins), and 10% in the VLDL (very low density lipoproteins). HDL represents a mixture of macromolecules of at least 7 subpopulations (LpA-LpF and Lp (a)). Genetics is an important determinant of HDL-cholesterol concentrations. It can be increased with regular exercise, moderate alcohol intake, decreased cigarettes, restricting dietary carbohydrate intake, decreased dietary saturated fats, estrogen,[2] Vitamin E[3], niacin but not clofibrate, cholestyramine nor thyroxine[4], and decreased with contraceptive pills and smoking.

The within-individual variability of serum HDL-cholesterol is similar to the variability of total cholesterol (4 to 14%). This variability is sufficiently high to render it preferable not to rely on the result of only one specimen. The problem is compounded by the variability of the different testing methods. HDL-cholesterol can be measured by ultracentrifugation which is time-consuming and requires expensive equipment; gel chromatography, which is also time-consuming and requires large volumes of plasma; or by electrophoresis, which is also time-consuming and is only semiquantitative. Most routine laboratories use polyionic precipitation technics that remove VLDL and LDL from plasma and measure the supernatant HDL-cholesterol. The precipitation methods correlate well with the ultracentrifugal separation, but they are not equivalent and give rise to differences in HDL-cholesterol quantitation.[5,6] Most cholesterol methods show good precision in the 200 to 300 mg/dl range, but not in the 40 to 50 mg/dl range. Enzymatic reagents have been found to be more sensitive than the acid reagents in these low ranges. A technical error of 5 mg/dl is significant since the average risk for men is about 45 mg/dl and increased risk for CHD is at about 35 mg/dl.



There are a number of different criteria used in evaluating HDL-cholesterol. Some authors prefer to report values as ratios.[7,8] The risk ratios are independent of age in contrast to the total cholesterol. The LDL/HDL ratio is probably better than the TOTAL/HDL ratio, but the latter is used more frequently because of the technical difficulty in determining LDL-cholesterol. The average risk ratio (Total/HDL) can easily be remembered as being 5 for males and 4.5 for females (Table 1). The magnitude increases with increasing risk. Others prefer to use absolute HDL-cholesterol values and not a ratio because the ratio makes the HDL value dependent upon other values (Table 2). Higher values correlate with decreased risk.

TABLE 1 *Total/HDL Ratio*

RISK	MALE	FEMALE
½ of average	3.43	3.27
AVERAGE	4.97(5)	4.44(4.5)
2 × average	9.55	7.05
3 × average	23.39	11.04

TABLE 2 *Risk Levels of HDL Cholesterol*

RISK	HDL-CHOLESTEROL
Dangerous level	Below 25 mg/dl
High risk	26 to 35 mg/dl
Moderate risk	36 to 44 mg/dl
AVERAGE RISK	45 to 59 mg/dl
Below average risk	60 to 74 mg/dl
Protective, assoc. w/longevity	OVER 75 mg/dl

However, determination of only the HDL-cholesterol value may be misleading. A person with an HDL-cholesterol of 35 mg/dl but total cholesterol of 105 mg/dl would be considered high risk by the HDL value, but is below average risk by the Total/HDL ratio.

REFERENCES

1. Gordon T, et al: HDL as a protective factor against coronary heart disease, *Amer J Med* 62:707-714, 1977.
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5. Warnick G R, et al: Comparison of current methods for HDL cholesterol quantitation, *Clin Chem* 25:596-604, 1979.
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8. Friedewald W T, et al: Estimation of concentration of low density lipoproteins cholesterol in plasma without the use of preparative ultracentrifugation, *Clin Chem* 18:499-502, 1972.



"HELLO, AJAX PHARMACY? I UNDERSTAND YOU HAD SOME DIFFICULTY READING MY HANDWRITING..."



Current Medical Diagnosis and Treatment

Los Altos, CA, Lange Medical Publications, 1981 pp 1,000 Index Price, $21.00

The 1981 edition of this valuable "desk-top" reference book on current medical practice will prove extremely useful to the busy clinician. At a time when the weight and price of the standard medical texts seem to increase exponentially it is a rare pleasure to find a volume which can be easily held in one hand and only costs $21. However, despite its modest size and price, all the common and many of the less common medical conditions are succinctly described in some 1,000 pages. There is a good index, while, for the intellectually curious, a list of current references follows each section.

Definitely a best buy for the specialist as well as the generalist. Highly recommended!

PHILIP JONES, M.D.

The Nail in Health and Disease.

By Nardo Zaias, M.D. New York, SP Medical Books 1980. 260 pp, index.

This is the new bible of the embryology, anatomy, histopathology, physiology, pathology, and treatment of the nails, and every practicing dermatologist should have it at hand for ready reference. Both medical and surgical therapy are discussed in detail, with an abundance of clear diagrams. The book is also lavishly illustrated with excellent clinical photographs, photomicrographs, and electron micrographs; one gets the impression that Dr. Zaias has incorporated every picture he owns, as well as some borrowed ones. The style of the text is clear and straightforward.

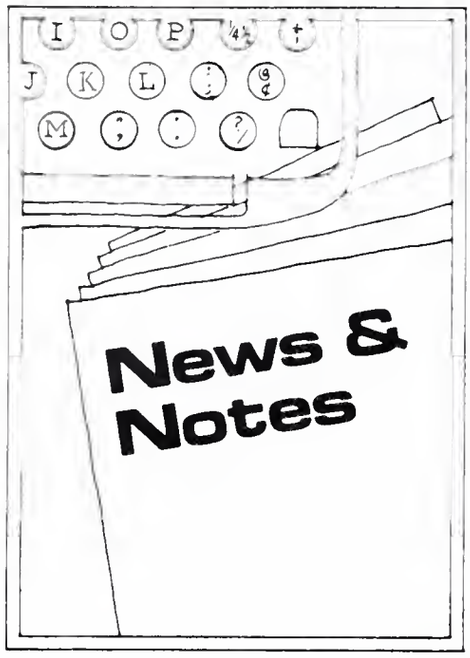
Dr. Zaias acknowledges his debt to Professor Vincente Pardo-Castello, who taught in Havana and published a small book on the nails some 40 years ago, and resided in Miami from the Castro revolution until his death in 1976. Until now, this little outdated volume, and Peter Samman's recently reprinted 1965 text, were the only works in English on the nails.

Zaias's intense devotion to the subspecialty of onychology since his residency days shows clearly in this admirable treatise. There are therapeutic pearls to be gleaned. Dermatologists with surgical orientation will find it especially valuable.

The book is attractively and durably bound, and printed on paper of good quality, and there is a good index.

One hopes that there will be a second edition, and that in it, the services of an editor and a proofreader will be provided by the publisher. Neither seems to have been much involved in the preparation of this one.

HARRY L. ARNOLD, JR., M.D.



HENRY N. YOKOYAMA, M.D.

Ten Commandments for living with People

(Lest we physicians forget . . .)

1. Speak to people. Nothing is so nice as a cheerful greeting.
2. Smile at people. Takes 72 muscles to frown, 14 to smile.
3. Call people by name. Sweetest sound is one's own name.
4. Be friendly and helpful. If you want friends, be a friend.
5. Be cordial. Speak and act to prove everything you do is a genuine pleasure.
6. Be genuinely interested in people. Just try and you can be like almost everyone.
7. Be generous with praise—and courteous with criticism.
8. Be considerate with others. There are often three sides to a controversy; yours, his and the right side.
9. Be alert to give help . . . what we do for others lives and is immortal.
10. Add to all this a good sense of humor, loads of patience, a dash of humility and you will be rewarded many fold.

(Clipping from a John S. Swift Company publication submitted by our realtor-appraisor friend Walter Loo . . .)

God Save Our Journal

When the HMA Council voted to discontinue our Journal, the following three appeals were made to the Council . . . The appeals are reprinted here in toto with our gratitude to Harry Arnold Jr, Fred Reppun, Robert Wilkinson and John Breinich . . . We are also deeply grateful to all those who voiced their disapproval of the move to terminate and who came to our aid in this time of crisis . . . The news is good at the time of this writing . . . We have a solution which we pray will meet the approval of the Council . . .

Dear Council Members:

The Publications Committee has discussed the problem of the excessive costs of the HAWAII MEDICAL JOURNAL during 1980 and would like to present the following for your consideration.

Publishing a medical journal of high quality, which is what the Hawaii Medical Association has done for the past 40 years under my editorship, is not a luxury, as many of the Hawaii Medical Association's activities during this time have been, but a fundamental basic responsibility, verging on a necessity. The Hawaii Medical Association is known for this activity in hundreds of libraries and in the offices of hundreds of doctors throughout the world. By it, we are able to maintain a line of communication, not only with members, but with many nonmembers and with neighbor island county societies. Cutting off such communications would surely have a serious, adverse effect upon the stature and the functions of our association. It costs us money, yes; it *should* cost us money.

Nevertheless, the fact that it costs us money—as much money as it has in the past year—is really the result of a series of events, small in themselves, but additive in their effects. In 1971 we lost our "free" executive managing editor when the Association decided to terminate her services. We still had a free editor, but the cost of actual production of the journal became an added cost to the Association at that time.

At about the same time all medical journals began to suffer from decline of national advertising, partly because of the result of FDA activities and a decline in the profits of pharmaceutical companies.

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We have had a hard time selling advertising space, probably because we kept a relatively low-key person, Mrs. Lilith Jurry. Mrs. Jurry's illness during much of 1980 (she recently died) was a further blow to local advertising contracts. We retained a mainland firm to solicit national advertising, and their performance proved so bitterly disappointing that we have terminated it. Printing costs went up in 1980; a further blow.

All this is water under the bridge; I review it only to help explain the problem that has developed.

We think we have a good chance of a very substantial increase in local advertising through a local firm which nearly 10 years ago offered to produce the Journal at no cost to the Association, but was turned down by Mr. Tom Thorson. We now plan to reopen discussion with them, and also to solicit support from our past advertising supporters on the basis of our financial crisis.

We consider that it is very likely that the increase of membership, which will probably result from the abandoning of the Unit Rule, will produce at least some increase of our subscription list and improve our advertising rates. Even though I have supported the Unit Rule over the years, I have done so with misgivings about the rightness of making membership in any medical organization compulsory, and I am now prepared to believe that it is time for Hawaii to join the overwhelming majority of State associations that have given it up. I also intend to appeal to individual physicians and to groups to make a donation to the Association in support of the Journal, and to start it off, I am pledging my own check for $1,000.

What the Publications Committee and I personally, as editor of the Journal for the past 40 years, most earnestly appeal for you to do is to permit us to explore these proposals for the next three months, rather than go through with your decision—which does seem somewhat precipitous—to stop printing the Journal with the March issue. Please let us publish at least until June; and if we have not come up with what you consider a reasonable proposal by that time, we will go quietly to the guillotine. Thank you.

Sincerely yours,

HARRY L. ARNOLD, JR., M.D.
Editor

28 February 1981

Neal E. Winn, M.D., President

Dear Neal:

I was very disappointed to read in the most recent issue of the HCMS Bulletin that the HMA Council has decided to terminate publication of the Journal. As I recall, the House of Delegates was not presented this alternative, or there might have been a serious discussion and floor fight. The H of D voted to continue publication as long as the figures indicated it was not losing inordinate amounts of money. At the time of our last annual meeting, it seemed that the Journal was pretty much self-supporting.

Let me say that I believe this is a bad move on the part of the Council. By giving up the Journal, the Association is cutting its lines of communication with its members, i.e. the Council is cutting its own umbilical cord before it, the Council, can live on its own, which it certainly can not.

If it is necessary for serious cuts in expenses to be made, despite the unpopular increase in dues that was supposed to remedy our needs, then I think it should be done elsewhere. The Journal, as our lifeline, needs to be preserved and supported with subsidies from our dues till the very last. As the Journal dies, so will the Association—mark my words.

Finally, I think it is rather underhanded for the news of this drastic move, as well as the cutting off of relations with Tel-Med, to reach us via a County organ and not directly from the HMA. You must realize that those of us who cannot or do not go to Council meetings, as we should do, perhaps, have to rely on news of the Council's doings via the Journal, and, such minutes are usually far in arrears. You can't say now that we were forewarned of this. That is why I call the move underhanded.

I hope the Council will reconsider, or at least bring such matters up for total membership awareness and participation BEFORE it makes such drastic decisions.

Aloha,

J.I. FREDERICK REPPUN, M.D.
Ex-delegate from Honolulu

February 24, 1981

Neal E. Winn, M.D., President

Dear Dr. Winn:

I heard last week of the decision to cease publication of the HAWAII MEDICAL JOURNAL. We are concerned not only because the Journal is the major medical publication in Hawaii, but also because the Library receives 89 other journals on an exchange basis and these will cease coming. The Library's journal collection is greatly enriched by this exchange program and we will not be able to continue these titles if they must be purchased since the annual subscription costs are $1,200 and many are available only on exchange. Generally, we have the only copy of these titles in Hawaii and the discontinuance of these titles will seriously affect the users of the Library.

I am enclosing a list of the titles being received on exchange which will be affected. I hope the Hawaii Medical Association can find a way to keep the HAWAII MEDICAL JOURNAL alive for the benefit of the membership, both directly through the articles in the Journal and indirectly through the exchange titles coming to the Library.

Sincerely yours,
ROBERT W. WILKINSON, M.D.
JOHN A. BREINICH

Journals Received on an Exchange Basis:

ACTA Medica et Biologica
ACTA Medica Okayama
ACTA Medica Philippina
ACTA Obstetrica et Gynaecologica Japonica
American Journal of Proctology, Gastroenterology and Colon & Rectal Surgery
Annales Paediatrici Japonici
Annales de la Societe Belge de Medicine Tropicale
Antiseptic
Arizona Medicine
Australasian Journal of Dermatology
Boletin de la Associacion Medica de Puerto Rico
Bulletin of the American College of Surgeons
Bulletin of the Institute of Maritime and Tropical Medicine in Gdynia
Bulletin of the Institute of Public Health
Bulletin of the Tokyo Medical and Dental University
Bulletin of the Yamaguchi Medical School
Cleveland Clinic Quarterly
Colorado Medicine
Delaware Medical Journal
Digest of Neurology and Psychiatry
Fukuoka ACTA Medica
Henry Ford Hospital Medical Journal
Hirosaki Medical Journal
IRYO
Japanese Journal of Experimental Medicine
Japanese Journal of Medical Science and Biology
Jikeikai Medical Journal
Journal of the Arkansas Medical Society
Journal of the Florida Medical Association
Journal of the Formosan Medical Association
Journal of Hygiene, Epidemiology, Microbiology and Immunology
Journal of the Indiana State Medical Association
Journal of the Iowa Medical Society
Journal of the Kansas Medical Society
Journal of the Kentucky Medical Association
Journal of the Korean Medical Association
Journal of the Maine Medical Association
Journal of the Medical Association of Georgia
Journal of the Medical Society of New Jersey
Journal of the Mississippi State Medical Association
Journal of the NARA Medical Association
Journal of the Philippine Medical Association
Kitano Hospital Journal of Medicine
Kobe Journal of Medical Sciences
Korean Medical Abstracts
Kumamoto Medical Journal
Lacma Physician
Lahey Clinic Foundation Bulletin
Maryland State Medical Journal
Materia Medica Polona
Mayo Clinic Proceedings
Medecine Interne
Medical Economics
Medical Journal of the Mutual Aid Association
Medical Journal of Osaka University
Mie Medical Journal
Military Medicine
Nagoya Journal of Medical Science
National Institute of Animal Health Quarterly
Nebraska Medical Journal
Nihon University Journal of Medicine
Ohio State Medical Journal
Ontario Medical Review
Pacific Science
Pennsylvania Medicine
Philippine Journal of Science
Physician East
Prensa Medica Argentina
Revista de Biologia Tropical
Rhode Island Medical Journal
St. Louis Metropolitan Medicine
San Francisco Medicine
Shikoku ACTA Medica
Sight-Saving Review
South Dakota Journal of Medicine
Sovetskaia Meditsina
Texas Medicine
Texas Reports on Biology and Medicine
Tohoku Journal of Experimental Medicine
Tokushima Journal of Experimental Medicine
University of Michigan Medical Center Journal
WHO Chronicle
Westchester Medical Bulletin
Western Journal of Medicine
Wiadomosci Parazytologiczne
Wisconsin Medical Journal
Yonago ACTA Medica

Professional Moves

The oriental zodiac has led us to believe that the Year of the Monkey is past and the Year of the Rooster is here but we just know that this is the Year of the Crises . . . (Esp. with the shooting of the President and the near termination of the medical journal . . .)

Anyway, the Chinese say, "Gung He Xin Nian Kuai Le" (Wishing you a happy new year) . . . We are still catching up with February, and March announcements . . .

In February, new urologist **Michael Uechi** opened his office at Kuakini Medical Plaza, Suite 507; pediatrician **Roy Ohtani** relocated to Medical Arts Bldg, Suite 102; eye and plastic man, **Wayne Wong** relocated to 615 Piikoi, Suite 510; general surgeon **Wayne Lee** announced his "long awaited" opening at the Queen's Physicians' Office Bldg, Suite 708; internist **George Seberg** associated with the Manoa Medical Clinic at 2752 Woodlawn Drive; plastic surgeon **F. Don Parsa** opened at Queen's Physicians' Office Bldg, Suite 804. On the Garden Isle, psychiatrist **Thomas Morelli** opened at the Lihue Shopping Center, Suite 216.

In March, internist **Jacklyn Stotts** opened her practice at St. Francis Hospital (Neighborhood Health Center) located at Kalihi Palama Multiservice Center, 333 N. King St, dermatologist **Frederick Maag** relocated to 1111 Bishop St Suite 515; cardiologist **John Cogan** relocated to the Queen's POB, Suite 810; pediatrician **Mitsuaki Suzuki** relocated to Aiea Medical Bldg, Suite 104; **Janice Smolec** practicing pediatric and Adolescent medicine relocated to Pearlridge Office Center, Suite 800; DDS and MD **Edwin Young** who does ENT and oral surgery relocated from the Alexander Young Bldg to St. Francis Medical Office Bldg, Suite 202; and R.D. Millard relocated to Investors Finance Bldg, Suite 308. Fronk Clinic announced that ophthalmologist **Donald Stroat** (who

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will continue his Kailua office) will join the Fronk Clinic . . . Straub Clinic announced that it will provide patient consultations at Mililani Medical Clinic . . . The Straub physicians are allergist **Robert Thune,** dermatologist **Robert Kim,** cardiologists **Raymond Itagaki** and **Robert White;** plastic surgeon **James Penoff,** neurosurgeon **Gonzalo Chong,** vascular surgeon **Robert Kistner** and OB man **John Spangler.**

Early Announcement of HMA Special Events:

The 125th HMA Annual Golf Tournament will be held this year on TUESDAY, OCTOBER 13, at the NAVY-MARINE GOLF COURSE. Shot-gun start at 1:00 p.m. SPORTSMEN'S NIGHT will be held that same evening at the HALE KOA MILITARY CLUB. Deep Sea Fishing and Skin Diving Tournaments will be combined and held either August 15 & 16 or August 22 & 23, 1981, depending on weather conditions . . . Please call the HMA office as early as possihle for reservations. Phone 536-7702.
SPORTSMEN'S NIGHT IS A PACKAGE WITH ALL SPORTS EVENTS.

Life in These Parts

Someone sent us the following sign: "NOTICE: While In Here Speak In A Low Soothing Tone and Do Not Disagree with Me in Any Manner—Please be informed that when one has reached 'my age' noise and non-concurrence cause gastric hyperperistalsis, hypersecretion of gastric juices and rubus of the gastric mucosa . . . and I BECOME MOST UNPLEASANT!!" (Wonder if anonymous meant it as a message?)

Cyrus Loo, Honolulu dermatologist, uses handwriting analysis in diagnosing skin problems. He was quoted in the Feb 24 issue of National Enquirer re, Ronald Reagan's penmanship: "His current handwriting samples display a slight backhand slant—which shows he is a calculated thinker who never acts on impulse and who means what he says." (don chapman Mar 2)

Hospital Costs Go Up, Up, Up! **George Mills,** chairman of The Hawaii Voluntary Cost Containment Committee, announced that costs were 16.77% higher during the 3rd quarter of 1980 than during the same quarter last year . . . Utilities rose 37%, interest on loans 24%, fringe benefits 22%, salaries and wages 17% and food, drugs and supplies 15% . . . The one shining light was the 8.5% decrease in malpractice insurance . . .

"Jumping is the one equestrian event that the young hotshots usually dominate—it really separates the men from the boys, the boys having an advantage . . . So last Sunday at Koko Head Stables, guess who beat state champ jumper Jeff Skov, Punahou senior and his closest competition, David Eith Jr.? 60ish **Dr George Henry,** radiologist . . ." (From don chapman's column)

The eighth annual Carole Kai Bed Race in Feb had 72 beds entered with each team paying the $500 entry fee (the proceeds benefit the Variety Club School) . . . "The prize for the Most Comical float went to Kapiolani Children's Medical Center for a pink and white gingham stork carrying **Dr Michael Light,** a baby doctor, in diapers . . ." (don chapman)

"Dis and Dot: Let's get this straight. **Dr Stewart Matsumoto** is a cardiologist who is on the staff at Queen's Med Center. He is 'in no way related to that kook who is posing as a doctor.' That would be the 'Dr Steven Matsumoto' who has been asking ladies indiscreet things over the phone. Police were glad about the item here warning ladies about the so-called doc—but it brought some weird calls to Dr Stewart Matsumoto's office." (From don chapman's column)

The Honolulu Marathon Association is looking for men over 40 who have not been jogging or running in the past few years, but are thinking seriously about running . . . The association has a research project to find out if training for the 1981 Honolulu Marathon will prevent osteoporosis or even reverse the effects of adult bone loss. KMC nuclear med head, **Richard Wasnich** (who is a pretty fast runner himself) is doing bone density measurements on all volunteers accepted for the study. Others participating in the study are **Jack Scaff, John Wagner** and **John Vogel** (an internationally recognized expert on bone mineral measurement) . . . The National Institute on Aging has funded $1 million for a 3 year period . . .

Robert Laird, chief of staff at Kona Hospital pulled no punches when he stated the State was handling the situation at the Kona Hospital emergency room in a way that is "unbelieveable, foolish and life-threatening." "How can a community the size of Kona tolerate a situation whereby a critically injured or ill patient is rushed to the emergency room only to wait at least 20 to 30 minutes for the physician to arrive?" He was referring to the fact that local doctors were now handling most of the emergency room responsibilities on an on-call basis, replacing HEPA . . . Henry Thompson, deputy director of the State Health Department said the problem began when HEPA was unable to find physicians to work in the Kona facility and wanted more money . . .

Ben Branch, long haired, sandal shod obstetrician at Kahuku Hospital, is credited with originating the first "birthing room" in the State eight years ago . . . Kapiolani Children's Hospital now provides its own brand of 'birthing room' or alternative birth center, designed to give a woman and her partner an experience that is un-hospital-like. **Ralph Hale,** chief of OB Gyn at Kapiolani, sees an increasing movement towards what he calls the "humanization" of childbirth. Ralph likes it just fine and says most doctors go along with most everything a pregnant woman wants . . .

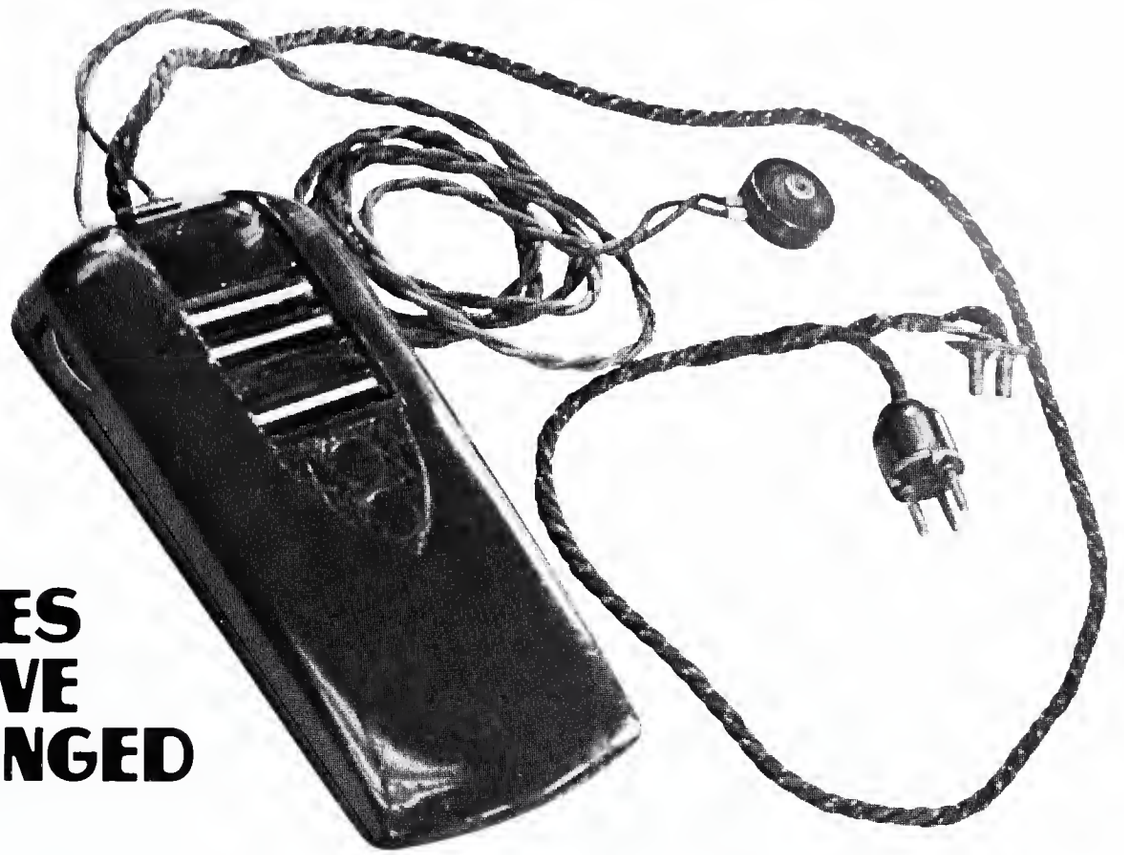
When the Honolulu Zoo's seven year old hippo lost 150 pounds the past year and 50 in the past two months (virtually skin and bones by hippo standard) to a mere 1,500 pounds, Vet Calvin Lum first zapped her with M-99 tranquilizer and tried the Xray machine in the Air National Guard aircraft maintenance hanger. The Xrays failed to penetrate her thick abdomen, so Lt Col **James Gallup** of the Honolulu Medical Group and gastroenterologist **George Lewis** laparoscoped the hippo's abdomen for half an hour and found no pathology.

In mid March, the Senate approved by a 17-8 vote marijuana legislation which will make marijuana available for the treatment of glaucoma, asthma, alcoholism, and patients receiving chemotherapy. Most oncologists are enthused because THC (delta 9 tetrahydrocannabinol) relieves the nausea and vomiting in chemotherapy, but others were not . . . **Niranjan Rajdev,** Honolulu Medical Group oncologist said, "If it is effective, it will be only one of the many effective drugs we use. It is not a panacea." **Thomas Lau,** head of the cancer dept St Francis Hospital said, "Doctors will use conventional drugs first and if it appears that those aren't working, we'll use THC." **Douglas Bell II,** chairman of HMA's legislative committee was surprised that alcoholism was being regarded as treatable by marijuana. "An alcoholic is the last person in the world you want to give drugs to because they already are abusing one substance." **Alexander Roth,** Kaiser allergist said, "To my knowledge, there have been no studies done which show marijuana to have any beneficial effect on asthma. Anything inhaled into the lung is not good for asthma. And right now we have excellent medications for asthma. I would not recommend THC." **Allan Kunimoto,** president of the Hawaii Opthalmologists Society agrees, "Studies have shown marijuana does drop ocular pressure. But this will just be another medication. We already have a lot of effective eye drops to treat glaucoma."

HPP (Hawaii Planned Parenthood) announced that it will offer mini-laparotomy sterilization at its 1164 Bishop St clinic for $600 as compared to the average $1,500 to $1,600 hospital surgical sterilization. **John Spangler,** local OB Gyn man will be assisted by **Frank Hurlbutt,** HPP medical director. HMSA and Medicaid coverage is pending.

SHPDA endorsed the Brown Schools of Hawaii, a subsidiary of the Healthcare International Inc in February, but another mainland company, Charter Medical Corp is appealing the decision. Brown Schools has proposed an 88 bed psychiatric hospital at a cost of $7,260,000 on a 14 acre site in Waipahu owned by Campbell Estate, whereas Charter Medical's proposal for a 80 bed facility would have cost $5,145,954.

Third in a Series



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Al Morris is program director of a new Senior Cardiovascular Rehabilitation Program at the Honolulu Medical Group Research and Education Foundation, a pilot program co-sponsored by the Hawaii Heart Association. The target group for the program is 8,500 people over 65.

Condom Vending Machines Get Push: A bill that has cropped up in the Legislature for at least 10 years has gained support with backing from the state Health Dept, Hawaii Planned Parenthood, Inc, Hawaii Medical Association, U of Hawaii Student Health Service and Family Planning Clinic. When Sen Dante Carpenter asked about the use of Saran wrap, which he said appears to be one of the current items in vogue, **Ned Wiebenga,** chief of the Health Department's Epidemiology Branch replied, "There is nothing new about that—there are a lot of makeshift methods . . . It's done to give the appearance of being exotic or different, but we don't recommend that." One dissident, a Marilyn White of Hauula maintains that it is a fallacious premise that unwanted pregnancies and VD would be reduced by vending machines. "There are girls who do not allow themselves to engage in sexual relations because they fear getting pregnant . . . Now they are being offered a risk free ride from their friendly neighborhood vending machine . . ."

Hors De Combat

Three Mainland consultants delivered a highly critical study of Hawaii's child protective services program. The study was requested by DSSH because of the State's crisis with increasing cases of child abuse, and neglect cases, understaffing, heavy caseloads and slow response to reported incidents. Calvin Sia heads the local subcommittee to oversee the evaluation. DSSH, the Children's Protective Services Center Advisory Committee and the Kapiolani-Children's Medical Center sponsored the study done by James Cameron, Katherine Armstrong and Barton Schmitt, mainland experts in child abuse and neglect . . .

The City Council proposed to transfer the emergency ambulance service to the state but City Health Director **Anna Maria Brault** testified that it was not timely and that the major difficulties facing the City Health Dept. were "manpower, morale, sick leave and other related problems . . . There is a shortage of trained medical intensive care technicians and emergency medical technicians. Because of the shortage, employees have been averaging 60½ more overtime and sick leave than other city employees . . ." State Health Director George Yuen concurred with Anna Maria's recommendations that it was not the time to transfer the ambulance services to the State . . . The city will continue to operate ambulances under a contract with the state . . . for another year . . .

When Circuit Judge Simeon Acoba Jr. seemed sympathetic to the guilty pleas of Walter Yokoyama by fining him $7,500 and ordering 500 hours of community service, City Deputy Prosecutor Duff Mendonca was relentless. He asked for some jail time because physicians enjoy a "very high degree of public trust" which makes their crimes more "troublesome." Mendonca said he hoped the court would take action that indicated "doctors don't enjoy special considerations, that they are accountable to the same laws as the rest of us are."

Talc-Coated Rice Sparks a Debate: The Puerto Rico Cancer Center reported that talc on rice might be a precursor to cancer. Both **Grant Stemmerman,** KMC pathologist and **Laurence Kolonel,** director of epidemiology, Cancer Center of Hawaii scoff at the relationship of talc-coated rice to stomach cancer. Laurence says, "Epidemiological observations don't seem to fit with the theory that talc-coated rice causes cancer." Grant is more firm in his conviction: "Although the Japanese in Japan have very high rates of stomach cancer, they consume no talc-coated rice. Japanese in Hawaii who eat large amounts of talc-coated rice, have a lower rate of stomach cancer. Groups here who use the most talc-coated rice, the Filipinos, have the lowest incidence of Gastrointestinal cancer. It is irrelevant whether there is asbestos in the rice or not. It is unwise to raise false dangers." **John McDougall,** Kailua physician, disputes this claim. John feels that asbestos fibers remain on talc-coated rice and these fibers are circulated throughout the body. "So wherever they lodge, they have the possibility of becoming carcinogens or co-carcinogens." **Jim Gallup,** Honolulu Medical Group pathologist says, "The association between asbestos and talc products is there. It is difficult to prove that talc ingestion does not lead to proclivity for cancer production."

Miscellany

(Yutaka Yoshida's Repertoire . . .)

Scene in a San Francisco wharf front restaurant . . . Boston visitor to waiter: "Can you get Schrod here?" Waiter, obviously offended, but maintaining his cool: "Sorry sir . . . this is a high class establishment . . ." (Fortunately, displaced Bostonian Suzie Ching was at the same table to explain that Schrod was a baby cod fish . . .)

Sportsmen

The First Annual Kuakini Medical Plaza Golf Tournament held at HICC on Friday pm March 27 was won by **James Tajima** . . . It is not the first for James. We remember how he won the First and Second Annual Kuakini Hospital Invitational Golf Tournaments . . .

The annual Kuakini Medical Center Invitational Golf Tournament was held one balmy April 3rd Friday afternoon at Mid Pac CC with 40 participants . . . When the "Sound and the Fury" had subsided, low gross was won by **Michael Okihiro,** low net was won by 80 year old **Herb Takaki** who shot a net 64, 2nd low net was **Dennis Murakami** with a net 65 and 3rd place was **Frank Fukunaga** with a net 67 . . .

Big Islanders were invited to a 9 am clinic on jogging in February at the Hilo High School track conducted by **Jack Scaff,** one of the founders of the Honolulu Marathon . . . Jack, long time president of the Honolulu Marathon Association, was recently elected Chairman of the Board . . .

Jerry Tucker was the unintentional matchmaker for Tripler physician **Andre Boissenvain** and QMC nurse **Judy Read** when he assigned them both to the same aid station on Kahala Ave for the 1980 Honolulu Marathon last Dec. 7 . . .

Chet Nierenberg, medical director of the 8-month old Honolulu Sports Medical Clinic, is avid skier, runner, swimmer, tennis and raquet ball player, weight lifter and aerobic trainer . . . Chet says, "The most successful people exercise . . . It definitely increases a person's sense of personal self worth, gives extra confidence and extra energy in the business world. You don't see a lot of fat, out of shape business people in Hawaii . . ."

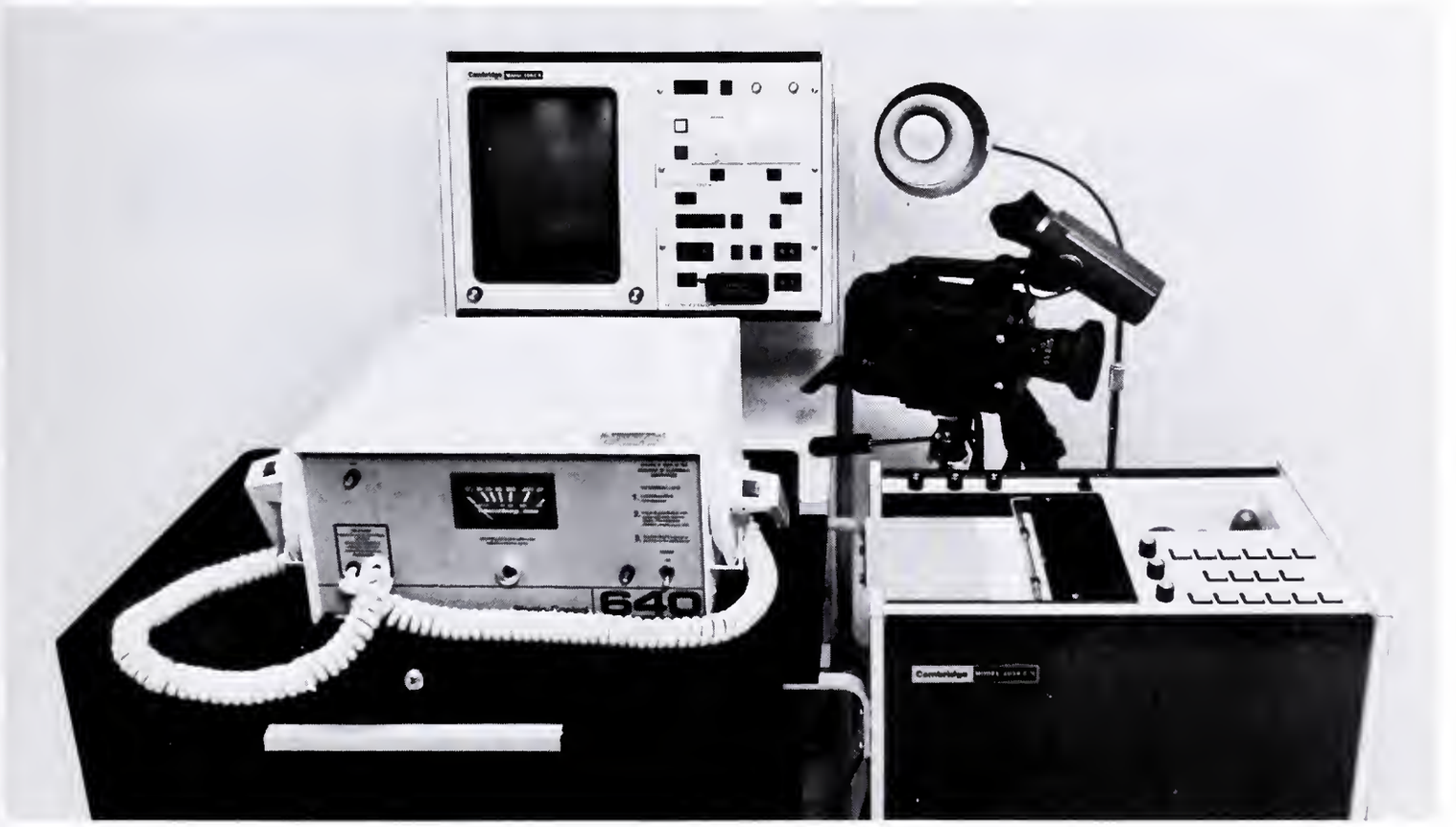
Frank Ferren, Kona physician, surgeon and marathoner hopes to finish the arduous 4th Annual International Triathlon where 400 physical fitness buffs from around the world will spend Valentines Day in Kona. The Triathloner starts with a 2.4 mile swim, bicycles 112 miles to Hawi and back and then runs 26.2 miles between Keauhou and Keahole Airport.

Our "Angels"

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Feelings vs.

Some people feel that I am misused and overused and that I'm prescribed too often and for too many kinds of problems.

The FACT is that approximately eight million people, or about 5 percent of the U.S. adult population, will use me during the current year. By contrast, the national health examination survey (1971-1975) found that 25 percent of the U.S. adult population experiences moderate to severe psychological distress. Additionally, studies of patient attitudes revealed that most patients have realistic views regarding the limitations of tranquilizers and a strong conservatism about their use, as evidenced by a general tendency to *de*crease intake over time. Finally, a six-year, large-scale, carefully conducted national survey showed that the great majority of physicians appropriately prescribe tranquilizers.

Some people feel that patients being treated with anxiolytic drugs are "weak," can't tolerate the anxieties of normal daily living, and should be able to resolve their problems on their own without the help of medication.

The FACT is that while most people can withstand normal, everyday anxieties, some people experience excessive and persistent levels of anxiety due to personal or clinical problems. An extensive national survey concluded that Americans who do use tranquilizers have substantial

Facts

justification as evidenced by their high levels of anxiety. It was further noted that antianxiety drugs are not usually prescribed for trivial, transient emotional problems.

Some people feel afraid of me because of the stories they've heard about my being harmful and having the potential to produce physical dependence.

The FACT is that there are thousands of references in the medical literature documenting my efficacy and safety. Extensive and painstakingly thorough studies of toxicological data conclude that I am one of the safest types of psychotropic drugs available. Moreover, I do not cause physical dependence if the recommended dosage and therapeutic regimen are followed under careful physician supervision. However, I can produce dependence if patients do not follow their physicians' directions and take me for prolonged periods, at dosages that exceed the therapeutic range. Patients for whom I have been prescribed should be cautious about their use of alcohol because an additive effect may result.

Many of the most knowledgable people feel that I became the No. 1 prescribed medication in America because no other tranquilizer has been proven more effective. Or safer.

The FACT is they are right.

For a brief summary of product information on Valium (diazepam/Roche) ℞, please see the following page. Valium is available as 2-mg, 5-mg and 10-mg scored tablets.

Valium®(IV)
diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy)
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contreindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Wernings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.
***Usege in Pregnency:* Use of minor tranquilizers during first trimester should eimost eiweys be evoided beceuse of increased risk of congenitel meiformetions es suggested in several studies. Consider possibility of pregnancy when instituting therepy; edvise petients to discuss therepy if they intend to or do become pregnent.**
Preceutions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.
Dosege: Individualize for maximum beneficial effect. *Adults:* Anxiety disorders, symptoms of anxiety, 2 to 10 mg o i d to q i d ; alcoholism, 10 mg t i d or q i d in first 24 hours, then 5 mg t i d or q i d as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t i d or q i d , adjunctively in convulsive disorders, 2 to 10 mg b i d to q i d . *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t i d or q i d initially, increasing as needed and tolerated (not for use under 6 months).
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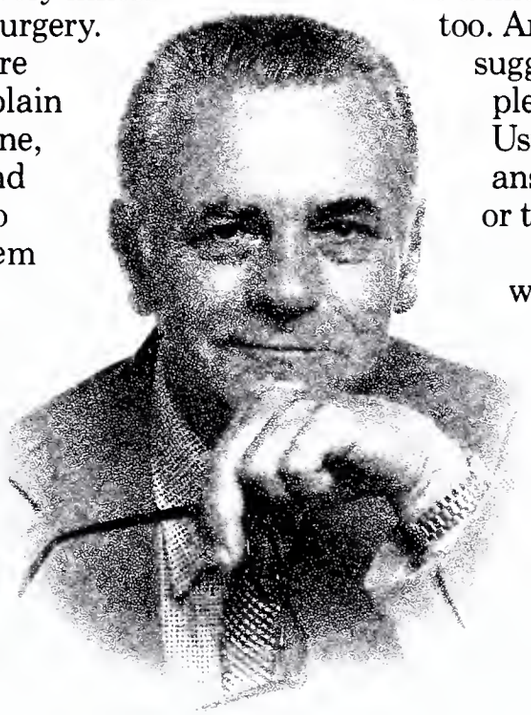
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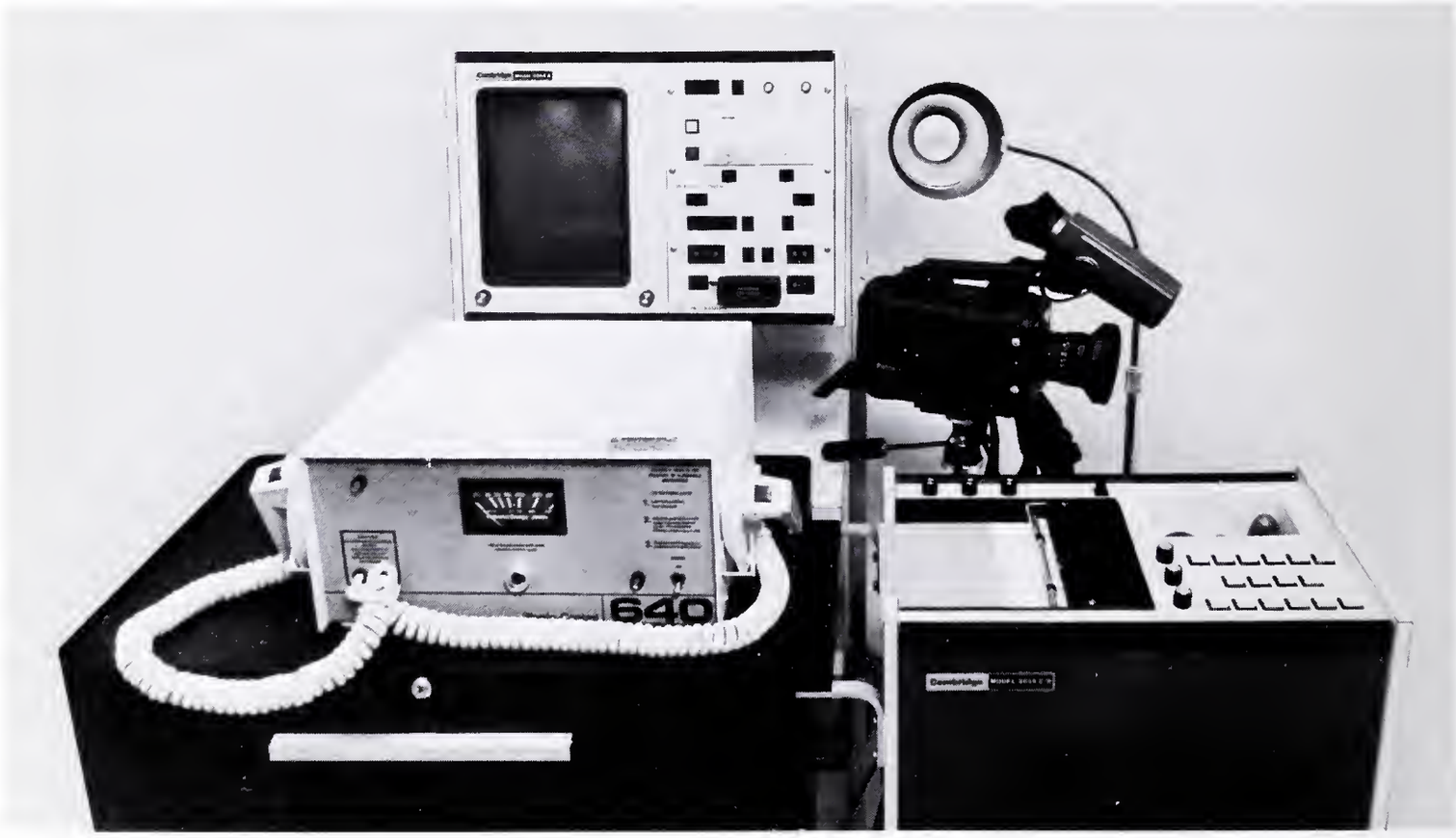
Old Fashioned Dialogue is Back.

HMSA Utilization Review Department

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Fireworks Trauma

GEORGE O. McPHEETERS, M.D.,* *and*
CLIFFORD J. STRAEHLEY, M.D.,† *Honolulu*

Emergency room records for the New Year's holiday of 1980 were reviewed at the 7 urban Honolulu hospitals. Fireworks injuries were found to represent approximately 2% of E.R. visits during the period of peak use. Burns accounted for ¾ of the injuries coming to medical attention. Many of the patients were children. We describe a serious fireworks accident occurring 2 weeks after the holiday. Fireworks trauma is a relatively uncommon, though potentially serious, hazard especially as it affects children. Our study failed to reveal an increased number of E.R. visits for respiratory complaints as a result of fireworks smoke.

The use of fireworks by the general public has been restricted in a number of states, often on medical grounds, for many years, but remains a controversial issue in some communities. The association with fire, trauma, vandalism and the fact that their time and place of use cannot be regulated adequately has lead to calls for a national ban of recreational pyrotechnics. Considering such a ban in 1974, the Consumer Products Safety Commission heard testimony from a number of sources including the National Electronic Injury Surveillance System (NEISS), various hospitals in Hawaii, and several medical associations and journals. Though a ban was not passed into law, several regulations governing labeling of fireworks, explosive content and construction of the devices were enacted.[1]

Recent medical literature lacks a survey of the types and severity of typical fireworks injuries. Wakely conducted such a review in New Zealand in 1974,[2] but the types of pyrotechnics available there, at that time, may not be representative of products presently available.

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Accepted for publication December, 1980.

In an effort to determine the medical impact of the use of fireworks we conducted a study of emergency room visits to Honolulu hospitals over the New Year's holiday.

Materials and Methods

Emergency room records of 3,366 visits were reviewed at the 7 civilian hospitals serving urban Honolulu. The number and type of fireworks injuries, and number of visits for bronchial asthma or acute, non-infectious exacerbation of chronic lung disease were recorded.

The number of patients seen in physicians' offices for these problems is unknown. However, the peaks of fireworks trauma appear to have occurred at times when offices were closed. Thus, we feel that this survey presents the vast majority of injuries coming to medical attention. The study was limited to the period between December 26, 1979 and January 2, 1980. Fireworks can be purchased legally in Honolulu between December 26 and 31, and may be legally used only for a 13 hour period over New Year's holiday by persons 18 years of age and older. Honolulu ordinances and Federal regulations limit the fireworks available in this city to sparklers, firecrackers with 50 mg. of powder or less, and a few other devices.

Results

There were 27 incidents of fireworks trauma. All were seen between December 31 and January 2, among 1,366 E.R. visits on those dates. They are summarized in Table 1. These injuries represented 2% of all visits for that 3 day period (Table 2). There were no hospital admissions resulting from these injuries.

TABLE 1—*Cases of Fireworks Injury Treated at Honolulu Hospitals*

CASE #	DATE	SEX	AGE	CAUSE	TYPE
1	12/31	M	13	firecrackers	contaminated corneal burns, conjunctivitis OU
2	1231	M	4	firecrackers	large partial thickness burn, chest
3	12/31	M	8	homemade bomb	laceration, leg
4	12/31	M	7	firecrackers	partial thickness burns, neck
5	12/31	M	8	sparkler	partial and full thickness burns, back
6	12/31	M	8	firecrackers	partial thickness burns, leg
7	12/31	F	19	firecrackers	partial thickness burns, leg and hand
8	1/1	M	28	sparkler	partial thickness burns, hand
9	1/1	M	27	firecrackers	corneal burn with ulcer
10	1/1	M	16	firecrackers	partial thickness burns, hand
11	1/1	M	5	firecrackers	partial thickness burns, fingers
12	1/1	M	16	firecrackers	lacerations, hands, arm
13	1/1	M	37	firecrackers	partial thickness burns, palm of hand
14	1/1	M	20	firecrackers	partial thickness burns, groin, penis, leg
15	1/1	M	19	firecrackers	partial thickness burns, hand
16	1/1	F	30	firecrackers	syncopal episode
17	1/1	M	29	firecrackers	partial thickness burns, face; corneal burns OU
18	1/1	M	61	firecrackers	partial thickness burns, arm
19	1/1	M	8	firecrackers	partial thickness burns, leg
20	1/1	M	16	firecrackers	facial lacerations, foreign bodies hit face
21	1/1	M	12	firecrackers	partial thickness burns, hand
22	1/1	M	8	firecrackers	acute conjunctivitis
23	1/1	M	13	homemade bomb	partial thickness burns, face
24	1/1	M	12	firecrackers	partial thickness burns, hand
25	1/2	F	11	homemade bomb	partial thickness burns, hand
26	1/2	M	32	skyrocket	partial thickness burns, hand
27	1/2	M	4 mo	firecrackers	severe fright reaction

TABLE 2—*Fireworks Injuries in Relation to Total E.R. Visits*

DATE	TOTAL E.R. VISITS	FIREWORKS INJURIES	%
12/31	442	7	1.6
1/1	561	17	3.0
1/2	363	3	0.8
	1366	27	2.0

TABLE 3—*Acute Exacerbations of Bronchial Asthma or Chronic Lung Disease*

DATE	TOTAL E.R. VISITS	# CASES	%
12/26	346	22	6.4
12/27	310	10	3.2
12/28	327	16	4.9
12/29	460	19	4.1
12/30	557	21	3.8
12/31	442	16	3.6
1/1	561	24	4.3
1/2	363	17	4.7
	3366	145	4.3

Hand and arm injuries accounted for 12 (43%) of the cases, and all but one of these were partial thickness burns. There were 4 eye injuries. In all, burns accounted for 21 (78%) of the cases. There were 3 .E.R visits for lacerations, 2 of which resulted from homemade bombs, and one occurred as a bystander dove through a glass door to avoid a string of firecrackers. Two patients without physical injury were seen: an infant became severely agitated after exposure to repeated firecracker explosions and required sedation; a pedestrian suffered a syncopal episode after a string of firecrackers exploded just above her head.

The average age of these patients was 17 years (range: 4 months-61 years). A total of 17 (63%) of the cases involved persons less than eighteen, and 8 (29%) were of children less than 10 years of age. Nearly 90% of the patients were males.

There was no relation between frequency of E.R. visits for asthma or chronic lung disease and time of heaviest fireworks usage (Table 3).

Discussion

The Honolulu medical community has a somewhat unique opportunity to see the trauma and other ill effects associated with the widespread and intensive use of fireworks. Hawaii was the only state to object to the proposed Federal ban on fireworks, and their popularity seems to have been maintained in this community. An estimated $6,000,000.00 was spent on fireworks for the 1980 New Year's holiday. Fireworks use is not restricted to those who legally purchase them, as our data shows.

For a city of approximately 600,000, the 27 injuries coming to emergency medical attention may appear to be a small number. Their significance lies in the fact that many of the patients were children and several were seen for injuries resulting from illegal, and exceptionally hazardous, applications of fireworks (eg, homemade bombs). This is in keeping with data from NEISS.[1] Such injuries have proved to be fatal in other instances. For example, a homemade fireworks bomb explosion in Kauai County, Hawaii, on January 13, 1980 caused one fatality, a potentially fatal abdominal wound, and several minor injuries to other children.

Police reports of this accident indicate that a group of playmates had collected powder from unspent firecrackers in a small jar, and with it at

table top height, ignited it. The resulting explosion fragmented the jar. A 3-year-old girl was hit in the face and chest by several shards of glass, one of which penetrated her heart, lacerating the right ventricle and ventricular septum. She died moments later. A 9-year-old boy was hit in the right upper abdomen. At surgery, his wound was found to extend nearly to the posterior surface of the liver near the vena cava. The majority of the glass could not be safely recovered and the patient was ultimately discharged with the recognition that complications requiring further surgery might arise in the future. Clearly, the potential for severe trauma is present in such accidents.

Studies from New Zealand and Great Britain have reported that serious eye trauma constitutes 50% of their fireworks injuries.[2] Our study is limited to users of 50 mg. firecrackers and sparklers, and may for this reason reflect fewer accidents affecting the eye.

Acute exacerbations of bronchial asthma or COPD have many causes. At the time of peak fireworks ignition on New Year's Eve, smoke clouds may be so dense as to limit visibility to less than 100 feet in many parts of Honolulu. This is particularly true when the air is calm, and has been felt to represent a risk for people with respiratory disease. The present study was conducted during a period of gentle breezes, which reduced the density and persistence of the smoke, and may account for the absence of increased E.R. visits for respiratory ailments.

Conclusion

A total of 27 incidents of fireworks trauma were seen at the 7 civilian urban Honolulu hospitals between December 31, 1979, and January 2, 1980. These represented 2% of all visits on those dates. Many of the patients were children, and a number of the injuries resulted from illegal use of fireworks. Burns accounted for 78% of the trauma. All but 3 of the visits resulted from firecracker mishaps. There were no hospital admissions resulting from this group of injuries. We conclude that fireworks trauma is surprisingly uncommon but represents a significant risk to children.

Acknowledgement

We wish to thank Dr. Robert Hamblin for his assistance in preparing this paper.

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1 Fireworks Devices, Consumer Product Safety Commission, Federal Register, 41, 9512-9525, 1976.

2 Wakely G. Accidents from Fireworks, *New Zealand Med J*, 79, 918-920, 1974.

3 Fireworks, editorial, *Lancet*, II, 858, 1975.

◆ ◆ ◆ ◆

Tax Relief

Tax Shelters and You

With taxes taking a bigger bite as incomes rise, tax shelters begin to look very attractive. But are they right for you?

There are a number of factors to consider before investing in a tax shelter. The best place to begin is to ask yourself whether a tax shelter investment is really necessary. For taxpayers in 50% plus marginal tax brackets, the benefit of a tax shelter is considerable compared to lower tax bracket taxpayers.

The second step would wisely involve researching the wide variety of tax shelter investments available on the market. Talk to qualified financial advisors regarding the different types and try to develop an understanding of what tax shelters can offer.

At this point, we should briefly mention what a typical tax shelter offers. Tax shelters offer deductions which can reduce your current taxable income, thus deferring the taxes on this income (deferring them until the tax shelter "turns around," that is, when it begins generating income). Most tax shelters are long-term, and the "turn around" means that you may go for several years before seeing any positive cash flow coming your way.

After your research, the next step may be selecting the type of tax shelter investment. The three major areas most often encountered include oil and gas, real estate, and equipment leasing. Each offers deductible expenses, such as depreciation, depletion, interest expenses, etc., which result in current year losses. (Future articles will discuss these three types in more detail.)

You may also want to consider the length of time involved and your cash needs in the next few years since your income picture may be changing. Most shelters are long-range and undesirable results such as depreciation recapture may occur if you elect to sell out of the tax shelter soon after investing. Most tax shelters require long-range planning.

Needless to say, you want to avoid shelters that are very risky and which are not a good investment. Many shelters that sound too good to be true may be quickly audited by the IRS and may be unsound investments as well.

There are additional considerations as well that are involved in every investment. These include the amount of risk involved, the leverage or liquidity requirements of the investment, and potential long-term affects on your tax picture. The important goal to keep in mind is to find the one that fits your particular financial picture.

JEFF CHASE

The preceding is a compendium of tax information written especially for doctors by the Honolulu office of Peat, Marwick, Mitchell & Co. Please direct any inquiries to John Marks, 531-7286.

Fatal Pulmonary Tumor Microembolism Complicating Peritoneovenous Shunt

STEPHEN Y.K. CHEW, M.D., *and* GRANT N. STEMMERMANN, M.D., *Honolulu*

• *One of the indications for the insertion of the peritoneovenous shunt is malignant ascites. According to LeVeen*[1]*, the shunt offers dramatic palliation in patients with malignant ascites, with improvement in appetite, gain in muscle mass and restoration of urine flow. Qazi and others*[2] *have similarly reported palliation of ascites in patients with malignant ascites. The complications associated with the use of the shunt include pulmonary edema secondary to fluid overload,*[1] *fatal disseminated intravascular coagulation*[3]*, and dislodgement of the shunt.*[4] *So far pulmonary embolism by tumor cells has not been mentioned as a complication of the procedure. This is a report of the rapid death of a patient from pulmonary hypertension following the insertion of a LeVeen shunt for malignant ascites.*

A 66-year-old Japanese man presented in September, 1978, with a 4-month history of weight loss and epigastric swelling. He had recovered from an anteroseptal myocardial infarction in 1975, with no subsequent complaints of chest pain, dyspnea, ankle swelling, or orthopnea. Work-up revealed an extensive gastric carcinoma. At laparotomy, the tumor was found to involve the entire stomach, with metastases to the regional lymph nodes and omentum. The liver was free of metastases. An 85% palliative gastrectomy and Billroth II procedure was performed; postoperative recovery was uncomplicated. The resected segment contained an adenocarcinoma of a mixed diffuse and intestinal type.[5] Signet ring cells penetrated the entire thickness of the gastric wall.

The patient was started on monthly dose of Mitomycin C, Adriamycin, and 5-FU. He was well until May, 1979, when he developed abdominal distention and discomfort. A peritoneal tap yielded 3 liters of serosanguinous fluid. Cytology of the peritoneal fluid revealed many malignant tumor cells similar to those in the stomach. The smear revealed an average of 50 cells/h.p.f. (X 450). Most of the cells were clumped together in aggregates of 8 to 10 cells, surrounded by abundant mucus (Fig. 1). His symptoms were relieved, but the ascitic fluid reaccumulated in a week.

On June 4 at 2:30 p.m., a LeVeen shunt was inserted under local anesthesia. The patient was well during the procedure, but within 15 minutes after completion of the shunt, he became acutely dyspneic. Arterial blood pH was 7.114; PCO_2 was 59.9mm Hg, PO_2 52.3 mm Hg, base excess −10.8 mEq/L, bicarbonate 18.7 mEq/L, and oxygen saturation was 69.4%. Chest x-ray showed slight to moderate pulmonary congestion with no cardiomegaly. He was given frusemide, nitroglycerine paste, morphine, and digitalis; intubated; and connected to a mechanical (MA-1) respirator with a F102 of 70%, total volume (TV) of 700 cc and a positive end expiratory pressure (PEEP) of 5 cmH_2O. At 6:00 p.m., a Swan-Ganz catheter was inserted; pulmonary artery pressure (PAP) was 25/3mmHg with a wedge pressure of 3mmHg. EKG showed a sinus tachycardia with no evidence of acute infarction. Blood pressure was 100 systolic.

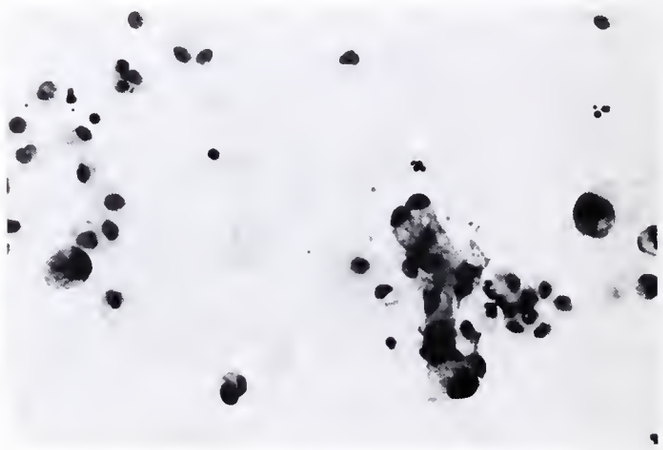


FIG. 1—*Aggregates of malignant cells from a representative area of ascitic fluid smear.* (×600 Papanicolaou)

At 10:00 p.m., the cardiac output was 5.01 to 5.21 L/min. with the PAP rising to 27/9mmHg.

From the Kuakini Medical Center, Pathology Department, 347 North Kuakini Street, Honolulu, Hawaii, 96817.

Accepted for publication May, 1980.

Overnight, the patient improved, was alert and could communicate by writing. The blood pressure was stable and had increased to 120/70mm Hg. The FI02 was reduced to 55% the morning of June 5. At 9:00 a.m. the PAP, however, had increased to 33/4. At 12:45 p.m., the cardiac output fell to 2.52 L/minute and the PAP increased to 50/24mmHg. At 2:30 p.m., the cardiac output was 2.7 with a PAP of 46/20mmHg. Arterial blood gases showed a pH of 7.5, PCO_2 of 29mmHg and PO_2 of 58mmHg. The patient complained by writing that he was "not getting enough air." At 3:20 p.m., the cardiac output was 2.52 L/minute with a PAP of 46/18 to 49/20mmHg (Fig. 2). Arterial blood gases showed a

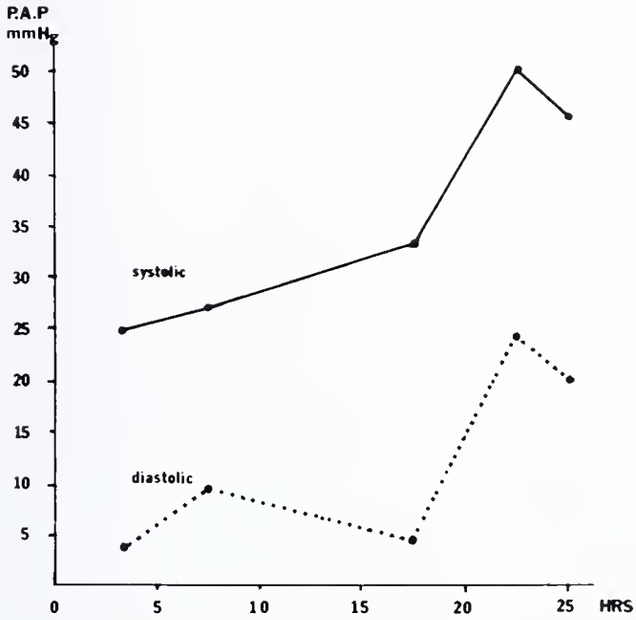


FIG. 2—*Pulmonary arterial pressure changes from 6 p.m. June 4 to 5 p.m. June 5.*

pH of 7.393, PCO_2 of 30.8mmHg and a PO_2 of 59.4 mmHg; base excess of −4.8mEq/L, bicarbonate 18.3mEq/L, and oxygen saturation was 90% on a FI02 of 60%, TV of 750cc and a PEEP of 5 cm H_20.

The patient, however, still complained he was not getting enough air. He later became cold and diaphoretic. A small amount of thick yellow and blood-stained sputum was aspirated from the trachea. A few scattered rales were present over both bases. At around 4:30 p.m., the cardiac output fell to 2.1 L/minute and the patient developed a right bundle branch block. He later went into cardiac arrest. Resuscitation was attempted but was unsuccessful.

Pathology

At autopsy, the LeVeen shunt was patent. The peritoneal cavity contained 2.5 liters of serosanguinous fluid. The peritoneal surfaces, omentum, and serosa of the intestines were matted together and studded with metastases. The lungs weighed 1,250 grams. The lungs showed no gross evidence of tumor metastases. The bronchi contained a small amount of pink frothy fluid. The pulmonary arteries and arterioles were patent, and contained no grossly visible emboli. The heart weighed 300 grams. The anteroinferior surface of the left ventricle was thinned in an area measuring 3 × 3 cm and the myocardium in this area was scarred. The

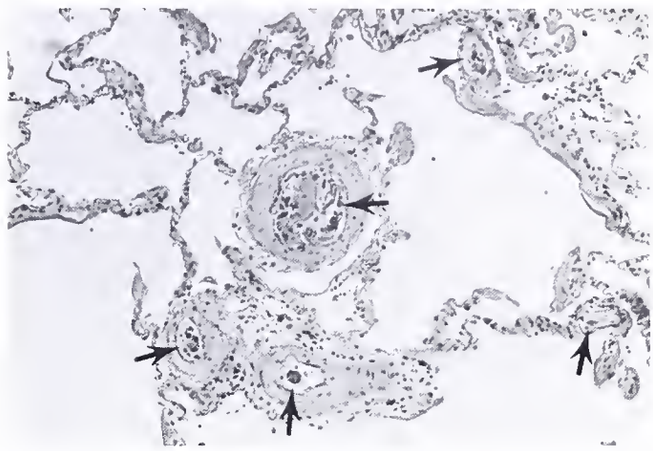


FIG. 3—*Emboli of malignant cells from ascitic fluid into pulmonary vessels.* (×100 H&E)

rest of the left ventricle appeared normal and measured 1.4 cm thick. The tricuspid ring was not dilated and measured 11.0 cm. The right ventricle was 0.5 cm thick. The cardiac chambers revealed a smooth endocardial surface. The left anterior descending artery was partially occluded by atheroma.

The pulmonary arterioles and capillaries from all portions of the lobes were filled with mucus-producing tumor cells (Fig. 3). These tumor cells were surrounded by an abundant amount of mucin which stained prominently with Alcian Blue. In some vessels, the main cause of impaction was the mucus rather than the tumor cells (Fig. 4). In much of the lung, there

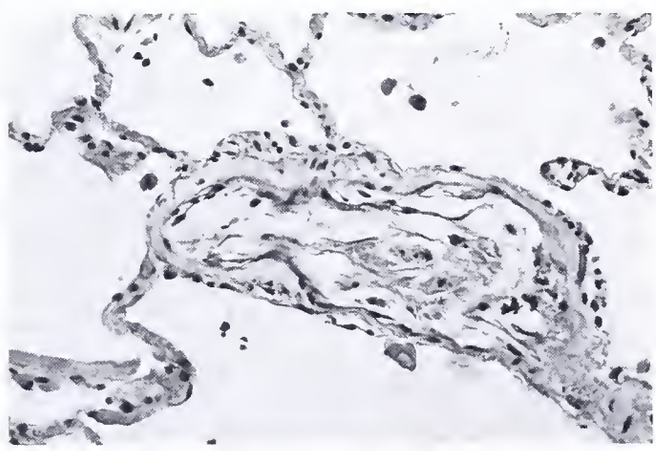


FIG. 4—*Single pulmonary vessel impacted with malignant cells surrounded by abundant mucus. These cells have a similar cytology to that found in the ascitic fluid.* (×500 H&E)

was no associated congestive change or alveolar filling process, but in other zones some alveoli contained a fibrin meshwork with an infiltrate of polymorphonucleocytes and macrophages. Microscopic examination of the heart revealed ex-

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tensive fibrosis in the anterior wall of the ventricle but no evidence of acute infarction.

The immediate cause of death in this patient was tumor microembolization to almost every pulmonary arteriole and capillary. The emboli were derived from ascitic fluid that had been shunted into the lungs. The mechanism of death was cardiac failure secondary to pulmonary hypertension. An early complicating bronchopneumonia probably contributed to the fatal outcome. The underlying cause of death was adenocarcinoma of the stomach with diffuse metastases to the peritoneum.

Discussion

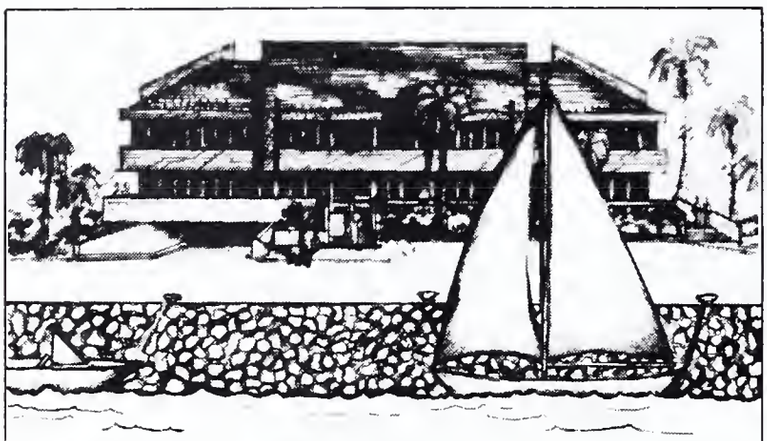
Peritoneal sepsis is one of the contraindications to the insertion of the LeVeen shunt. Stanley[6] recommends that cell count and culture should be done on ascitic fluid to detect infectious peritonitis shortly before the procedure; but the presence of malignant cells, per se, has not been mentioned as a contraindication to the insertion of the shunt. In LeVeen's[7] experience with 15 patients with malignant ascites, 9 had malignant cells in the ascitic fluid. In spite of this, the shunt appeared to offer marked palliation; tumor embolization into the pulmonary arterioles was not mentioned. One patient was reported to have lived 4½ months after the shunt, and another as long as 2 years. On average, the survival time was less than 6 months. In Qazi's[2] experience, the shunt appeared to offer palliation in 12 out of 20 female patients with malignant ascites from ovarian, breast, and colon carcinoma. The presence of malignant cells in ascitic fluid was not mentioned in this study. The 8 patients who did not benefit from the procedure had impaired cardiac or renal function or loculated ascites, or had a high ascitic fluid protein content.

This case establishes the fact that malignant cells from ascitic fluid may embolize in the pulmonary arterioles, causing pulmonary hypertension and respiratory failure. It may be possible that the amount of mucus produced by the tumor cells is just as important a factor in the development of this complication as the number of tumor cells in the ascitic fluid.

Caution should therefore be exercised in the selection of patients with malignant ascites who are candidates for the insertion of the shunt. If the ascitic fluid contains large number of clusters of tumor cells, as in this case, a shunt should not be considered.

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7. LeVeen HH, Wapnick S, Grosberg S, et al: Further experience with peritoneovenous shunting for ascites. *Ann Surg* 184:574, 1976.



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Editorials

Edmund T. K. Ing, M.D. Honored

The Hawaii Chapter of the American Academy of Family Physicians at its annual meeting in February, 1981, honored a charter member, Edmund Tai Kam Ing, M.D. and his family. Dr. Ing has been in the active practice of medicine, surgery and obstetrics—family practice—for 50 years. He continues to practice office medicine only, mornings only, for 6 days a week, at the corner of Beretania and Kalakaua streets in Honolulu.

Edmund was born In Tai Kam in Honolulu February 6, 1902. His father came from China as a teenager, a farmer, and he continued to farm most of his life here. He was also a cook for the Herbert Dowsett family and for Dr. Raymond on Maui at Ulupalakua Ranch. Mr. In returned to China to marry Edmund's mother and bring her to Hawaii. They had 13 children, 8 of whom are still living. The family was poor but worked hard, parents and children alike. It was a sacrifice for the family to send Walter Ing Akana, Ed's older brother, through Cornell Medical College. He later practiced in Rome, New York, and is now deceased. Edmund wanted to become a doctor too, but his father told him that he had all he could do to send one son off to be an M.D.

Edmund attended McKinley High School, where he played football for 4 years with such football greats as Willie Wise. Ed beat Willie out as an end and relegated the latter to the backfield after they once collided in practice; Willie was the more severely hurt. Ed, too, suffered many broken bones in those days of little personal protection. Louis Gaspar was their quarterback. Sam Kahanamoku was a classmate, also. Graduating from McKinley in 1921, Edmund went to the University of Hawaii, but gave up football in favor of study and part time work. He got his bachelor's degree in 1925, the year UH had its "Wonder Team" in football. I remember seeing them beat the University of San Francisco in the old Mo'iliili stadium when I was a boy of 12. Ed remembers Walter "Chocolate" Chung, M.D., Herbert Takaki, M.D., and James Kuninobu, M.D., as his classmates.

Upon graduation from the University of Hawaii, Ed was offered a job as a teacher of science at the UH Hilo by Mr. Givens, the well-known head of the Territorial Department of Public Instruction; Givens had a considerable influence on young Ing. However, Ed had an opportunity to go to China with a select group of college men from the West Coast under the auspices of the Y.M.C.A., sponsored by Alexander Hume Ford, the founder of the Pan-Pacific Union in Honolulu and later the Pan-Pacific Surgical Association, of which Ed was and is still a member. Edmund at this time was a "Chun Gow Lau," which translates into "one who changes his religion." He had become a Christian, much against his father's wishes. Ed later became the first oriental deacon of Central Union Church.

While in China, he met students who were in opposition to the foreigners from the many world powers that had staked territorial claims in Peking and Shanghai. Instead of returning home to Hawaii, Ed was persuaded by Richard Sia, M.D. (Cal Sia's father) and by M. F. Chung, M.D., to attend Peking Union College, the Johns Hopkins in China, a satellite of the famous Baltimore medical school. He later transferred to St. John's in Shanghai, which was affiliated with the University of Pennsylvania medical school. Ed served a year of rotating internship at St. Luke's Hospital in Shanghai before being awarded his M.D. degree in 1930.

Edmund had spent five years in China, and it was natural to him to return to the University of Pennsylvania medical school itself, in Philadelphia. By then he had changed his name to Edmund T. K. Ing, haole style, instead of the Chinese In Tai Kam. Two years later he had earned his Master's degree in Medical Science, majoring in urology. While at this postgraduate school, he met and married Audrey Dunseath of Scotch-Irish-English descent, a business college student, and brought her to Hawaii.

The Ings have been married for 49 years. They have 2 sons and 3 grandchildren. Malcolm is the elder; he is our popular TV star and MC for the Hawaii Medical Association's "Your Body, Your Mind" program. Malcolm is an ophthalmologist in Honolulu. The younger son is Donald, a psychologist, in Denver, Colorado. Edmund and Audrey have a medical grandson-in-law, Denton Watumull, married to Malcolm's daughter Karen. "Denny" is a third year student at the UH School of Medicine.

The young doctor Ing returned to Honolulu in 1932 and opened up an office for general practice in Louis Gaspar, Sr.'s vacated office on Kukui Street. Ed and George Tyau, another charter member of ours, shared one nurse and a waiting room, but were independent solo practitioners. Later they moved to L. Q. Pang's vacated offices on Beretania at Punchbowl. In the meanwhile, Ed, who had been commissioned a second lieutenant in R.O.T.C. upon graduation from UH, switched to the Army Medical Corps and was called up for active duty early in World War II. He served as urologist at the old Tripler Army Hospital in Moanalua; at the end of the war he held the rank of Lt. Col. He had kept his private office going part-time. Later, he and George Tyau moved to Keeaumoku Street just makai of the Board of Agriculture and Forestry, where they remained for many years. They parted company amicably in 1971 when Edmund moved to his present location.

Edmund has been on the staff of all the major Honolulu hospitals. He also served at Leahi TB Sanatorium, and at Hale Mohalu Leprosarium, and at the famous VD Clinic at Palama Settlement with the late Pete Irwin, member H.A.F.P. and also urologist. Ed was often chief of the departments of urology in

these hospitals and, for a long time, he and Rollo Brown were the only urologists in town, in fact in all the Hawaiian Islands. Many general practitioners and surgeons, however, did their own urology in those days of scarce specialists. Ed came to center his activities at St. Francis Hospital. He was Chief of Staff there in 1948. Ed did a lot of charity work and is particularly proud of having built up the Child Health Conference (well baby clinic) in Chinatown in the basement of a church.

Dr. Ing joined the Honolulu County Medical Society, and with it the Hawaii Territorial Medical Association and the AMA in 1933. He has been a member and Fellow of the International College of Surgeons since way back when. In 1951, with K. C. Chock, H. Q. Pang and George Tyau among others, he helped found the Hawaii Chapter of the American Academy of General Practice, as it was then known, and is, therefore, a charter member and now a Life member. In 1974, he earned the degree of Fellow of the American Academy of Family Physicians.

In 1972, Edmund returned to China to take a course in acupuncture and he does practice that art now too. He went again in 1978 to the People's Republic of China, and marveled at the changes from 50 years before. "Now, everything is clean and neat and there is no visible poverty," says Ed, but in the next breath he says, "But, the USA is unique for its freedom."

Edmund is in love with the United States and says so over and over again. He is sorry that he has lost his familiarity with spoken Hawaiian; he remembers as a child hearing his father speak it fluently. His father had first been married to a Hawaiian woman, with no issue from that union.

Edmund has been a member of Lions International, a service organization, for 45 years. He has belonged to many clubs and associations, and has been active in community work. He was twice president of the prestigious See Dai Doo Society and is currently a director. He is a golfer, had a hole-in-one in a medical tournament, and once won a major trophy at the Oahu Country Club. He is a life member of the University of Hawaii Alumni Association and one of its most staunch supporters.

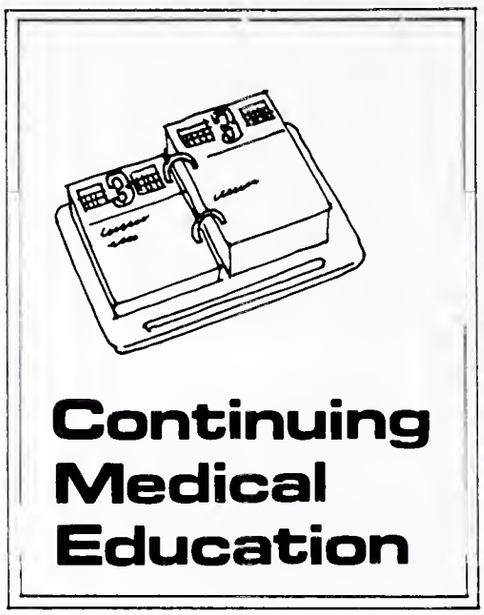
Ed is very proud of his doctor son, but feels that the younger medical graduates are not as dedicated to selfless hard work as was his generation. His advice to young medicos is: "If you're going into medicine for the money in it, don't! Be a physician only if you are dedicated to helping people in relief of their suffering."

Edmund Ing, we, your colleagues in the family practice of medicine, present you with a plaque as an expression of our esteem for your 50 years of active practice, and for your role model as a family doctor, as a respected member of our community, and as an upstanding citizen of this country and of the world.

Aloha,

J. I. Frederick Reppun M.D.

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CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

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LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, First Thursday, 12:45 p.m. and Fourth Tues. 12:30 p.m. w/Maui Mem. Hsp. Held on Oahu at Am. Cancer Society main conf. room, 200 N. Vineyard, Honolulu.

John A. Burns School of Medicine

1. Dept of Medicine
 - A. Case Conferences, Second and Fourth Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 - B. Grand Rounds, First and Third Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 - C. Endocrinology Grand Rounds, Third Wednesdays, 5:30-6:30 p.m., Queens University Tower, Room 506.
 - D. Hematology Grand Rounds, Second and Fourth Mondays, 12:30-1:30 p.m., Queens University Tower, Room 721.
 - E. Cardiology Grand Rounds, First and Third Tuesdays, 5:30-6:30 p.m., Queens University Tower, Room 508.
 - F. Infectious Disease Grand Rounds, Second and Fourth Tuesdays, 5:00-6:00 p.m., Queens Nalani I Conference Room.
 - G. Dermatology Grand Rounds, Second Wednesday, 7:30-8:30 a.m. Queens, Queen Emma Clinic.
 - H. Pulmonary Grand Rounds, Second and Fourth Thursdays, 4:30-5:30 p.m., Queens Kamehameha Auditorium.
2. Division of Nuclear Medicine
 - A. Technical aspects of Nuclear Medicine, Second Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506, 1½ credits.
 - B. Rounds, Fourth Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506.
3. Dept. of Obstetrics and Gynecology
 - A. Grand Rounds, Wednesday 7:30-8:30 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
4. Division of Orthopaedics
 - A. Fracture Conference, Tuesdays, 5:00-6:00 p.m., Queens University Tower, Room 618.

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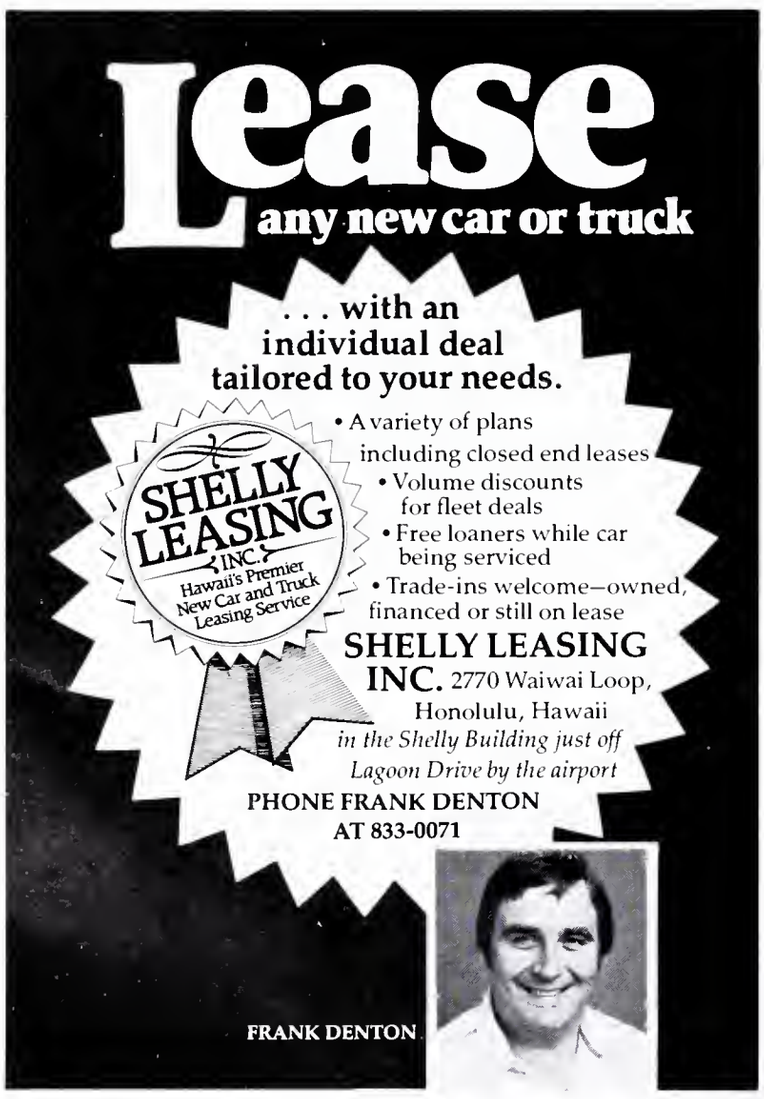
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 B. Pediatric Conference, Mondays 12:45-1:45 p.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 C. Pediatric Infectious Disease Conference, Thursdays, 12:30-1:30 p.m., Kapiolani-Children's Medical Center, Third Floor Conference Room.
 D. Neonatal Ground Rounds, Fridays, 8-9:00 a.m., Kapiolani-Children's Medical Center, Administrative Conference Room.
6. Dept. of Psychiatry
 A. Grand Rounds, Fridays 8:00-9:30 a.m., Queens University Tower, Room 618.
7. Dept. of Surgery
 A. Grand Rounds, First, Second and Third Saturdays, 7:30-9:00 a.m., rotating hospitals.
 B. Statistical M and M, last Saturday, 7:30-9:00 a.m., rotating hospitals.
 C. Journal Club, First and Third Tuesdays, 6:00-8:00 p.m., Queens University Tower, Room 620.
 D. Medical-Surgical G.I. Rounds, Second Tuesday, 7:00-8:00 a.m., Queens University Tower, Room 506.
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 A. Conf., Wednesdays, 8-9:00 a.m. Kaiser 4th Floor Conf. Room.
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9. Department of Physiology
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10. University of Hawaii, John A. Burns School of Medicine Grand Rounds, Third Thursday, 4:30-6:00 p.m., Queen's University Tower, Room 618 or BioMed Building.
11. H1 Oncology Group, one Monday a mnth., 12:30-1:30 p.m., The Cancer Center, 1236 Lauhala St., 4th Floor Conference Room.

Federation of Emergency Medicine-Maui

1. **Cardiology for the Emergency Physician.** Every Monday, 9-10:00 a.m.-Maui Memorial Hsp. Conf. Rm #1. (For spec. topics or further info. contact: Federation Office (808) 244-7629, or Dr. C. T. Mitchell, (808) 244-9056.
2. **Journal Club in Emerg. Medicine.** 2 hrs. Cat. 1. MMH Conf. Rm. #1. 9am-11 a.m.
 6/22/81 Annals in Em Med, 2/81; Abstracts in EM 3/81 - J. Mills
 7/20/81 Annals in Em Med, 3/81; Abstracts in EM 4/81 - C. Mitchell
 8/24/81 Annals in Em Med, 4/81; Abstracts in EM 5/81 - D. King
 9/21/81 Annals in Em Med, 5/81; Abstracts in EM 6/81 - S. Burkle
 10/19/81 Annals in Em Med, 6/81; Abstracts in EM 7/81 - P. McCallum
 11/23/81 Annals in Em Med, 7/81; Abstracts in EM, 8/81 - J. Mills
 12/21/81 Annals in Em Med, 8/81; Abstracts in EM, 9/81 - C. Mitchell

Hawaii Thoracic Society

1. Pulmonary Med., Clinical case presentations & current research in pul. med. with U of H Sinclair Chest Club. Third or Fourth Wed., ea month, 7:30 p.m.-9:30 p.m. For further info contact: Rosemary Respicio, B.S.N. at (808) 537-5966.

Hickam Clinic

1. Clinical Correlation Conference, First Thursday, 11:00 a.m.
2. Didactic—our staff, Second Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, Third Thursday, 11:00 a.m.
4. Radiology Conference, Fourth Thursday, 11:00 a.m. (Contact Aurora Macapinlac, M.D., M.C., 449-5770)

Hilo Hospital

1. Orthopedic Conference, First Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, Second Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, Third Friday, 12:30-1:30 p.m.
5. C.P.C., Second Friday, 12:30-1:30 p.m.
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2. Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. 1.
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4. Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. 1.
5. Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. 1.

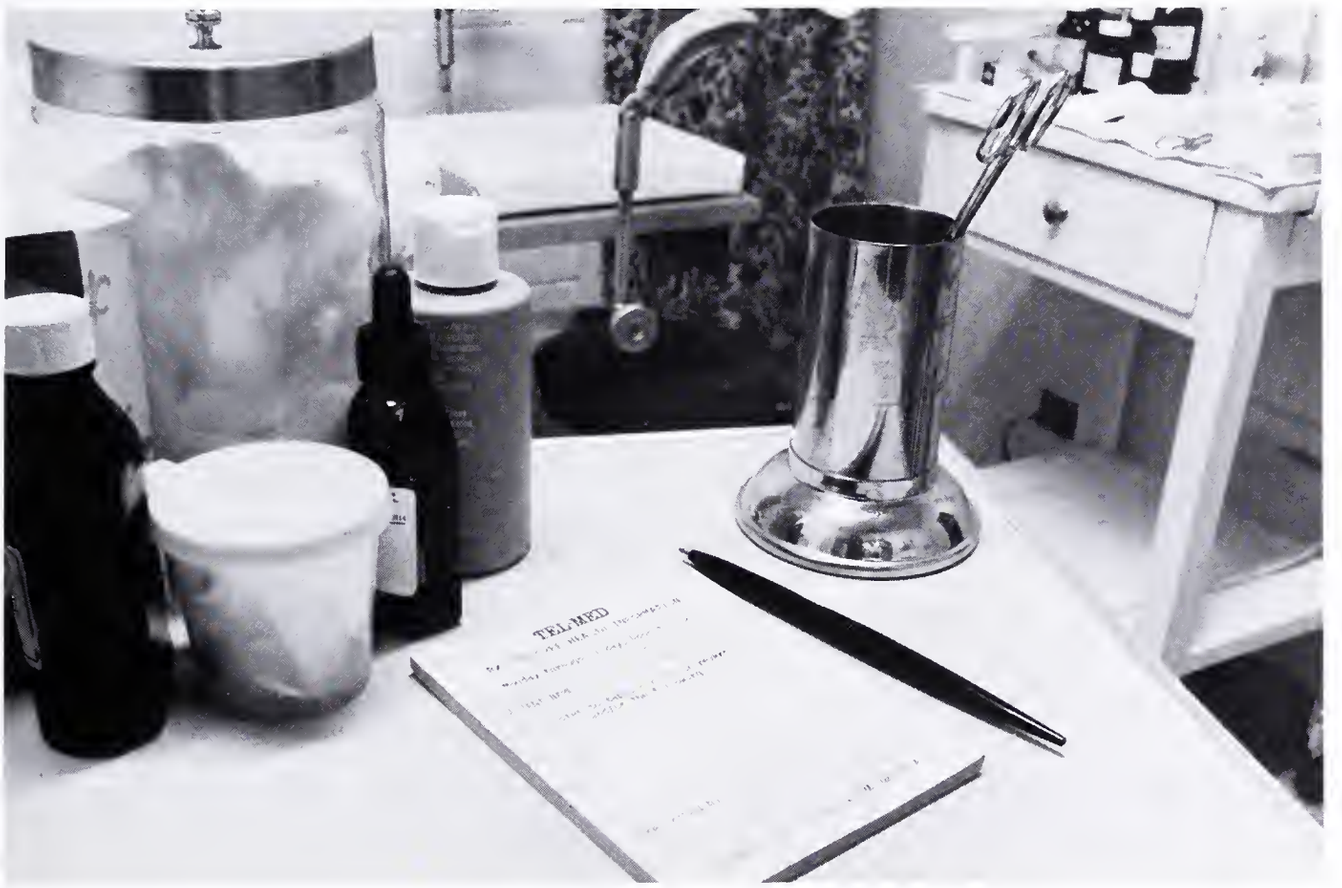
(Contact CME Dept.-Kaiser for further information)

Kapiolani-Children's Medical Center

1. Pediatric Grnd. Rnds. Every Thursday, 8-9:00 a.m. Aud.
2. Pediatric Conf. Mondays, 12:45-1:45 p.m. 2nd Floor Aud.

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3. Neonatal Grnd. Rnds., Fri. 8-9:00 a.m., Conf. Rm. B.
4. Pediatric Infectious Disease Conf., Thursdays, 12:30-1:30 p.m. 3rd Floor Conf. Rm.
5. Ob-Gyn Conf. Tues. 1-2:00 p.m. Aud.
 First—Didactic Presentation
 Second—Perinatal-Neonatal Topics
 Third—Obstetrics Topics
 Fourth—Gyn Topics
6. Tumor Brd.—Oncology Conf. First and Third Fri. 1-2:00 p.m., Aud.

Kuakini Medical Center

1. Department of Ophthalmology Meeting, 1st Tuesday, 12:30-1:30 p.m.
2. Department of Medicine Meeting (Statistical), 4th Tuesday, 1:00-2:00 p.m.
3. G. I. Conference, 5th Tuesday, 8:00-9:00 a.m.
4. Nephrology Conference, 2nd Wednesday, 8:00-9:00 a.m.
5. Oncology Conference, 1st, 3rd and 4th Thursday, 7:30 a.m.-8:30 a.m.
6. Pulmonary Conference, 1st Thursday, 1:00-2:00 p.m.
7. Surgical Conference, 1st and 2nd Friday, 12:45-1:45 p.m.
8. Surgical M & M Conference, 4th Friday, 12:45-1:45 p.m.

Maui Memorial Hospital

1. Thurs. Conf. 7-8:00 a.m. Staff Dining Rm.
 1st—Dept. of Medicine
 2nd—Dept. of Surgery
 3rd—Dept. of OB/GYN
 4th—Dept. of Pediatrics
 5th—Elective
2. Tumor Brd. every Mon. 12:15-1:15 p.m.—Tumor Conf. Telephone Task Force—Third Tues. 12:15-1:15 p.m.
3. Dept. of Emergency Med., Third Mon., 7-8:00 a.m.
4. Diagnostic Radiology—Fourth Tues., 12-1:00 p.m.
5. SFH-UH Hematology Conf., Third Thursday, 12:30 p.m.Sullivan-4 Classroom.
6. SFH-UH Surgical Grand Rounds, First, Second, & Third Fridays, 7:30 a.m., Sullivan-4 Classroom.
7. Visiting Professor Programs (for further info call CME office at St. Francis).

The Queen's Medical Center

1. ENT Conferences, First and Second Fridays, 7:30 a.m., Small Dining Room.
2. Medical Conferences, Every Friday, 8:00 a.m., Kam Auditorium.
3. Ob/Gyn Conferences, Second and Fourth Mondays, 1:00 p.m., Kam Auditorium.
4. Ophthalmology Conference, Fourth Tuesday, 5:00 p.m., Queen Emma Eye Clinic.
5. Orthopaedic Conferences, Every Wednesday, 7:00 a.m., Kam Auditorium.
6. Pathology Conferences, Every Wednesday, 7:30 a.m., Surgical Conference Room.
7. Pediatric Grand Rounds, Fourth Thursday, 12:30 p.m., Nalani 1 Conference Room.
8. Surgical Trauma Conference, Second Tuesday, 4:30 p.m., Kam Auditorium.

 Basic Science Lectures, Every Wednesday, 7:15 a.m., Queen's University Tower, Room 618.

St. Francis Hospital

1. SFH-UH Tumor Conf., Every Monday, 7:30 a.m. Sullivan-4 Classroom.
2. SFH-UH Nephrology Conf., First Monday, 1:00 p.m. Sullivan-4 Classroom.
3. SFH-UH Endocrine Conf., last Monday, 12:30 p.m. Sullivan-4 Classroom.
4. EENT Meeting, First Tuesday, 7:00 a.m., Sullivan-4 Classroom.
5. SFH-UH Hematology Conf., Third Thursday, 12:30 p.m. Sullivan-4 Classroom.
6. SFH-UH Surgical Grand Rounds, First, Second, & Third Fridays, 7:30 a.m., Sullivan-4 Classroom.
7. Visiting Professor Programs (for further infor call CME office at St. Francis).

Straub Clinic & Hospital

1. Straub Professional Seminar meets the Second Tuesday of each month, from 5:00-6:30 p.m. in the Credit Union Meeting Room (2nd Floor, Credit Union Bldg).
2. Surgical Mortality and Morbidity Conference meets every Fourth Thursday of each month, from 7:00-8:00 a.m. in the Doctors' Dining Room.
3. Cardiac Surgery Conference meets the Third Tuesday of each month, from 4:30-5:30 p.m. in the Doctors' Dining Room.
4. Department of Anesthesiology meets the Second Tuesday of each month from 7:00-8:00 p.m. in the Doctors' Dining Room.
5. Community Peripheral Vascular Conference meets the Fourth Thursday of each month from 5:00-6:30 p.m. in the Doctor's Dining Room.
6. Visiting Professor Program meets monthly from 7:00-8:00 a.m. in the Doctors' Dining Room.
7. Urology Inservice meets every other month on the Third Friday from 8:00-9:00 a.m. in the Doctors' Dining Room.
8. Neuropathology Clinical Correlation Conference meets the Third Thursday of each month from 7:30-8:30 a.m. in the Straub Morgue.
9. OB-GYN Pathology meets every Fourth Monday of each month from 12:30-1:30 p.m. in the Administration Conference Room (ACR).
10. Urologic Pathology meets every First Monday of each month from 8:00-9:00 a.m. in the Doctors' Dining Room.
11. Friday Noon Conference meets every Friday of each month from 12:30-1:30 p.m. in the Doctors' Dining Room.

*Note: All conferences are subject to change. Monthly calendar will be available upon request.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—Second Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Miscellaneous

HMA Maternal and Perinatal Mortality Study Cmte. First Monday ea. month-5:30 p.m. 320 Ward Ave., S 200. Cat. 1 on hr. for hr. basis.

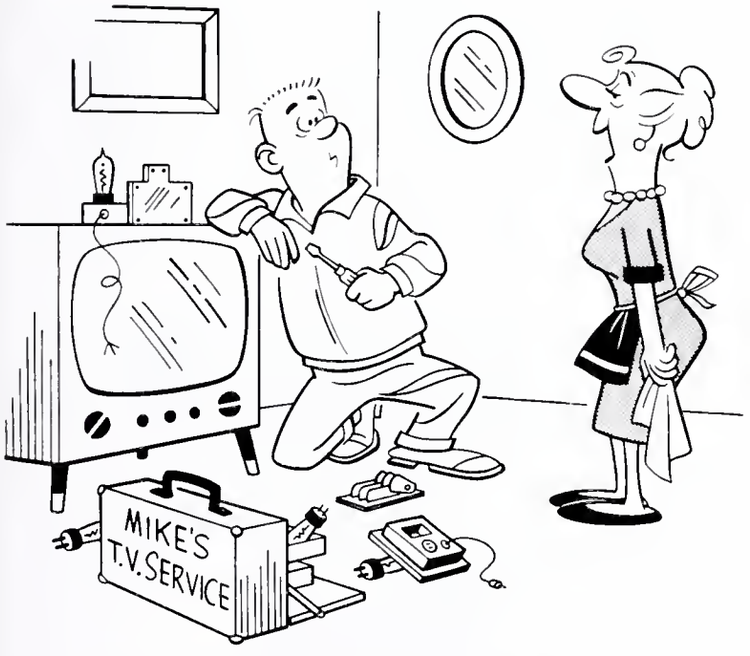
SPECIAL EVENTS

June 15, 24, 1981	Radiology of Bone & Joint Disease. San Diego Radiology Res & Ed Found., Box 2305 La Jolla, CA 92038. Cospons: Am Coll of Radiology. Held: Kona Surf Resort Htl, Kona, HI
June 24, 28, 1981	The Samson Thoracic Surg. Soc. Held at Hyatt Htl., Maui. 15 hrs. Cat. 1. Contact: Samson. Western North American 13 Elm St., Manchester, Mass 01944.
July 11, 18, 1981	Endocrine Metabolic Crse., U of So. CA Schl of Med., 2025 Zonal Ave., LA, CA 90033. Held: Mauna Kea Beach Htl, Kamuela, HI.
July 22, 29, 1981	Refresher for Technologists & Pathology. USC Schl of Med., 2025 Zonal Ave., LA, CA 90033. Held: Kauai Surf Htl, Kauai, HI.
July 31, Aug 4, 1981	ACP Internal Medicine Update, Spons: ACP & J.A. Burns Schl of Med, Honolulu, Contact: Dee Chang (808) 947-7457. Held: Wailea Beach Htl, Maui.

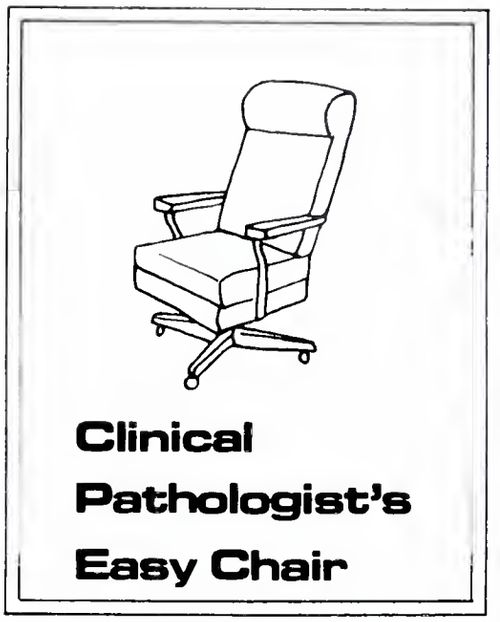
Aug 7, 8, 1981	Ophthalmology Annual Mtg., Alumni U of CA Irvine Coll. of Med., Irvine, CA. Held: Kona, HI.
Aug 15, 26, 1981	24th Annual Postgraduate Refresher Course, USC School of Medicine in assoc. with TAMC, Honolulu and Maui, up to 37 hours, $375 tuition.
Aug 25, 26, 1981	Gynecological Urology: A Teaching Course, Sheraton-Waikiki, UC Irvine, Jack R. Robertson, 1430 E. Main St., Santa Maria, CA 93454.
Aug 26, Sept 7, 1981	Third Ann. Radiology for Nonradiologists. San Diego Rad. Res. & Educ Found, Box 2305, LaJolla, CA. 92038; cospons: Am Col of Radiology. Held: Kauai Surf Resort Htl, Kauai. 35 hrs. Cat. I.
Aug 29-Sept 4, 1981	Concepts in Infertility-1981, Royal Lahaina, Maui, Stanley Friedman, The Edward Tyler Medical Clinic, 921 Westwood Blvd., LA 90024.
Oct 12, 16, 1981	Oncology Board Review, Princess Kaiulani, ACP, Dr. Thomas Hall, Cancer Center of Hawaii, 1236 Lauhala, Honolulu 96813.
Oct 12, 16, 1981	AMA Regional & Scientific Mtg/HMA Annual Mtg. Held: Ilikai Htl, Waikiki. Contact: AMA Dept. of Mtg. Serv.; 535 No. Dearborn St., Chicago, IL 60610.

OUT OF STATE

For information on any out-of-state programs or courses, refer to September 3, 1980 Supplement to JAMA or call the HMA Office.



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FRANCIS FUKUNAGA, M.D.

Hyperparathyroidism

The number of parathyroidectomies has increased in recent years. Before the use of multichannel chemical analyzers, primary hyperparathyroidism was detected only after symptoms of hypercalcemia were evident. The routine determination of serum calcium in blood chemistry profiles has allowed the detection of primary hyperparathyroidism at a much earlier stage.

Although an elevated serum calcium is the most frequent indicator of hyperparathyroid disease, most cases of hypercalcemia are due to other causes. There are many factors that control serum calcium, such as the parathyroid hormone (PTH), Vitamin D metabolism, diet, drugs—especially the diuretics, renal tubular function, bone resorption, and intestinal function. There often are large variations of serum calcium concentrations from day to day, especially in people with disorders of calcium metabolism. The serum calcium in hyperparathyroidism may be only slightly elevated and even normal on some days. To rule out intermittent hypercalcemia, serum calcium should be determined more than once, especially when one determination is over 10 mg/dl. Once hypercalcemia is documented, further studies should be done to determine its etiology. Cancer is the most common cause of hypercalcemia, usually due to bone metastases with release of calcium, but there are some cancers, most notably bronchial, renal, ovarian and colonic, that may produce a parathyroid-like hormone that can enhance bone resorption. The cancer is usually obvious when the hypercalcemia is due to a malignancy, but it occasionally may be occult. Serum electrophoresis should be done to exclude hypercalcemia due to multiple myeloma; it may also give a clue to sarcoidosis. The erythrocyte sedimentation rate is usually elevated in cancer but not in primary hyperparathyroidism.[1] Steroids can often depress the hypercalcemia of cancer but only rarely that of primary hyperparathyroidism.

The parathyroid hormone maintains the ionized calcium concentration in blood. It is secreted in response to a decline of serum ionized calcium, and increased calcium concentration inhibits PTH secretion. PTH is a polypeptide of 84 amino acids and is cleaved into peptide fragments. The biologically active portion is the amino-terminal or N-fragment, but it is

not found in circulation in any appreciable concentration due to either rapid binding to the receptors or rapid clearing from blood. The forms detected in blood are the intact PTH and the carboxyl or C-terminal fragment. The C-terminal fragment is the principal form of the hormone detected in serum, but it is biologically inert. The intact has a very short half-life of minutes, while that of the C-terminal fragment is 10 to 20 times longer. Most laboratory radioimmunoassays measure the C-terminal fragment and, therefore, the assay is only an index rather than a true measure of the intact hormone. However, there is good correlation between the C-terminal fragment concentration and gland secretory activity. Some feel that the C-terminal fragment assay reflects gland activity better than the intact PTH. It shows less overlap between normals and hyperparathyroids than the intact PTH.

The determination of the C-terminal fragment concentration is more useful in the differential diagnosis of hypercalcemia, but the intact PTH assay is preferred in selective venous catheterization in the preoperative localization of hyperfunctioning parathyroid glands.[2] The C-terminal fragment is elevated in 95% of primary hyperparathyroidism, but the occasional case with normal C-terminal fragment level may show an increase of the intact PTH. The C-terminal level is usually normal in the hypercalcemias due to cancer and is low or undetectable in hypervitaminosis and sarcoidosis. The C-terminal fragment level is markedly elevated in 85% of secondary hyperparathyroidism due to chronic renal failure, because these fragments are normally eliminated through the kidneys. Secondary hyperparathyroidism, due to lack of Vitamin D and some malabsorption states, also shows increased PTH with normal or decreased serum calcium.

PTH correlates linearly with serum calcium in normal individuals. The true normal PTH must be based on the serum calcium levels; the interpretation of PTH should be made with simultaneous serum calcium determinations.[3] Patients with hypercalcemia due to other causes have low PTH levels, while in primary hyperparathyroidism, the PTH is inappropriately elevated for the calcium concentration. There is an overlap of PTH levels between normal individuals and primary hyperparathyroidism, but separation of these groups can be made by plotting serum PTH as a function of serum calcium. Borderline hypercalcemia may require a series of three determinations of the PTH and calcium. Some endocrinologists also determine the urinary cyclic AMP levels in cases of hypercalcemia, since it is elevated in hyperparathyroidism.[4,5] However, nephrogenous cAMP is also increased in both normocalcemic and hypercalcemic lung cancer patients.[6]

REFERENCES

1. Murray, TM, et al, Hypercalcemia and cancer: an update, Canad Med Assoc J, 119:915-910, 1978.
2. Hawker, CD & Di Bella, FP, Radioimmunoassay for intact and Carboxyl-terminal parathyroid hormone: clinical interpretation and diagnosis, Ann Clin Lab Sci 10:76-88, 1980.
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4. Broadus, AE, et al, Nephrogenous cyclic AMP as a parathyroid function test, J Clin Invest 60:771-783, 1977.
5. Kitamura, T, et al, How to differentiate hyperparathyroid patients among intermittent hypercalcemic urinary stone formers, J Urol 123:328-334, 1980.
6. Kukreja, SC, et al, Elevated nephrogenous cAMP with normal serum PTH levels in patients with lung cancer, J Clin Endocrinol & Metab 5:167-169, 1980.



The Care and Feeding of Athletes, *by George V. Mann, Sc.D., M.D., New York, LeJacq Publishing Co., 1980, 124 pp.*

This book discusses physiology and fitness at the level of a layman. A glossary is supplied to help the reader manage the use of technical terms familiar to all physicians. This would be an appropriate text in health education to be used with instruction for the majority of students in the ninth grade. Tenth- through twelfth-grade students should be able to read this book independently.

Short-comings include a very brief and mostly decade-old bibliography with no references. Certain tables are inappropriate; for example, one table entitled "The Energy Costs of Various Activities" shows running 24 miles per hour as using up 35 kilocalories per minute. The obvious fallacy is that no human has ever run 24 miles an hour.

I certainly would disagree with the chapter entitled "Nutritional Strategy," in which the author states that there is no particular advantage or disadvantage in extremes of food mixtures, whether they are very high in carbohydrates or very high in fat. He also states that the fattening that is associated with age tends to reach its maximum between the ages of 55 and 60 and is probably a teleologic preparation for the illnesses and exigencies of old age.

ROBERT L. SMITH, M.D.

Our "Angels"

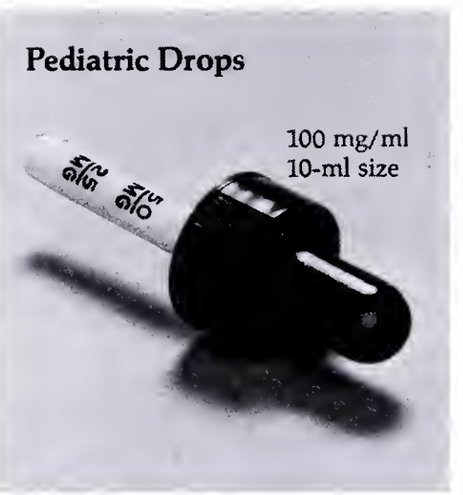
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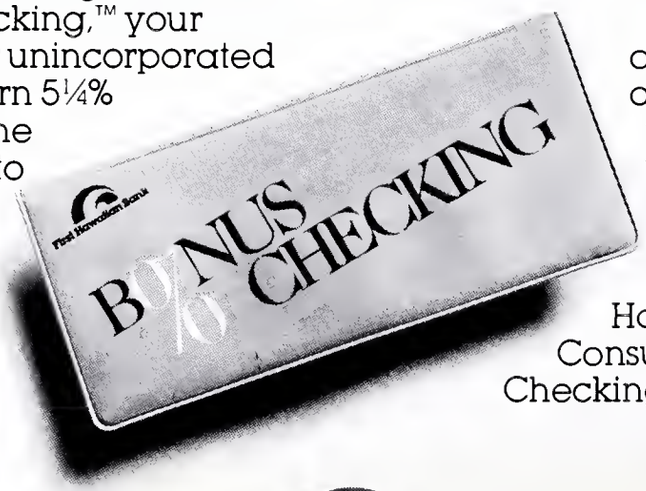


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Hawaii Medical Journal

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Some people feel that I am misused and overused and that I'm prescribed too often and for too many kinds of problems.

The FACT is that approximately eight million people, or about 5 percent of the U.S. adult population, will use me during the current year. By contrast, the national health examination survey (1971-1975) found that 25 percent of the U.S. adult population experiences moderate to severe psychological distress. Additionally, studies of patient attitudes revealed that most patients have realistic views regarding the limitations of tranquilizers and a strong conservatism about their use, as evidenced by a general tendency to *de*crease intake over time. Finally, a six-year, large-scale, carefully conducted national survey showed that the great majority of physicians appropriately prescribe tranquilizers.

Some people feel that patients being treated with anxiolytic drugs are "weak," can't tolerate the anxieties of normal daily living, and should be able to resolve their problems on their own without the help of medication.

The FACT is that while most people can withstand normal, everyday anxieties, some people experience excessive and persistent levels of anxiety due to personal or clinical problems. An extensive national survey concluded that Americans who do use tranquilizers have substantial

Facts

justification as evidenced by their high levels of anxiety. It was further noted that antianxiety drugs are not usually prescribed for trivial, transient emotional problems.

Some people feel afraid of me because of the stories they've heard about my being harmful and having the potential to produce physical dependence.

The FACT is that there are thousands of references in the medical literature documenting my efficacy and safety. Extensive and painstakingly thorough studies of toxicological data conclude that I am one of the safest types of psychotropic drugs available. Moreover, I do not cause physical dependence if the recommended dosage and therapeutic regimen are followed under careful physician supervision. However, I can produce dependence if patients do not follow their physicians' directions and take me for prolonged periods, at dosages that exceed the therapeutic range. Patients for whom I have been prescribed should be cautious about their use of alcohol because an additive effect may result.

Many of the most knowledgable people feel that I became the No. 1 prescribed medication in America because no other tranquilizer has been proven more effective. Or safer.

The FACT is they are right.

For a brief summary of product information on Valium (diazepam/Roche) ℞, please see the following page. Valium is available as 2-mg, 5-mg and 10-mg scored tablets.

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diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety, symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis; stiff-man syndrome, convulsive disorders (not for sole therapy)
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.
***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults:* Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d., alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d., adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
Supplied: Valium® (diazepam/Roche) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available in trays of 10.

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Proceedings of The House of Delegates

PROCEEDINGS OF THE HOUSE OF DELEGATES HAWAII MEDICAL ASSOCIATION

SPECIAL MEETING
May 2, 1981

The Special Meeting of the House of Delegates was called to order by President Neal E. Winn on Saturday, May 2, 1981, at 1:30 p.m., in the auditorium of Kapiolani-Children's Medical Center.

Dr. Kwong Yen Lum, Secretary, called the roll. Present were: Drs. Neal E. Winn, Ann B. Catts, Douglas B. Bell, II, Kwong Yen Lum, Henry Fong, Ernest Bade, Eugene Wasson, III, Mark Wentworth, Albert Chun-Hoon, James Lumeng, Andrew Morgan, Myron Shirasu, Nadine Bruce, Thomas Cahill, E. Lee Simmons, Arch Wigle, Denis Fu, Herbert Chinn, William Iaconetti, George Mills, Samuel Allison, J. Alfred Burden, William Dang, George Goto, Marion Hanlon, O. D. Pinkerton, Calvin Sia, and Theodore Tomita. Delegates from county societies included: Honolulu—Vincent Aoki, Murray Berger, Allan Izumi, Doris Jasinski, Charles Judd, Melvyn Kaneshiro, Thomas Lau, Carl Lehman, Michael McCabe, James Orbison, Iwao Shiraki, Herbert Uemura, Thomas Whelan, Terry Wong, Dan Yoshioka, Walter Young, James McGuire, John Spangler, Thomas Au, Nathaniel Ching, Helen Sullivan, Patrick Walsh, Nancy Edwards, James Bennett, Norman Nakashima, William Wong; Maui—William James, Clifford Moran, Russell Stodd; Hawaii—Ruben Casile, A. Scott Miles, and Richard Lundborg.

Dr. Richard Ando was appointed to serve as parliamentarian for the meeting. Drs. Charles Judd and Herbert Uemura were appointed sergeants at arms. Appointed as tellers were: Drs. Nadine Bruce, Thomas Cahill, James Lumeng, and William Iaconetti.

The President stated that the special session of the House of Delegates was convened for the specific purpose of considering proposed bylaws amendments concerning: (1) additional component societies within a single county of the State (Section 1.03 of bylaws), and (2) mandatory county/state association membership with voluntary AMA membership (Sections 2.01 and 2.085 of bylaws). It was agreed that the HMA Council's amended bylaws amendment 1.03 would be voted upon by the House of Delegates, instead of the original amendment proposed by the Bylaws Committee. The House was informed that a two-thirds (⅔) vote of House members present and voting would be required for adoption of the bylaws amendments. The President reported that the recommended "Guidelines for Additional Component Societies" would be considered by the House at its annual meeting in October, in the event that proposed amendment 1.03 is adopted at this special meeting. A motion to adopt the modus operandi was made, seconded, and passed.

The reference committee was appointed as follows: Dr. Ann Catts (Chairman), Ernest Bade, Henry Fong, Eugene Wasson, III, and Mark Wentworth.

The reference committee was in session beginning at 2:00 p.m.

The Special Meeting of the House of Delegates was reconvened at 3:00 p.m. The reference committee presented the following report:

1. **REFERENCE COMMITTEE REPORT:** Your Reference Committee first considered the bylaws change relating to the establishment of component medical societies, and recommends adoption of the proposed bylaws change as submitted by the HMA Council. The guidelines will be referred to the House of Delegates in October, and your Reference Committee believes that no. 2 of the guidelines should remain as a guideline and not be included in the proposed bylaws change.

HOUSE ACTION:

Adopted amendment 1.03, by vote of 54 (in favor) to 1 (against), as follows:

a. Delete existing Section 1.03:
"Only one component medical society shall be chartered in any one county of the State."

b. Add new Section 1.03: "ANY CONTIGUOUS URBAN OR RURAL AREA IN ANY ONE COUNTY OF THE STATE MAY MAKE APPLICATION TO THE HMA HOUSE OF DELEGATES TO FORM A COMPONENT MEDICAL SOCIETY. APPROVAL OF SUCH APPLICATION MAY BE MADE BY THE

HMA HOUSE OF DELEGATES BASED UPON GUIDELINES ESTABLISHED, FROM TIME TO TIME, BY THE HMA HOUSE OF DELEGATES.

2. **REFERENCE COMMITTEE REPORT:** Your Reference Committee strongly believes that every physician should belong to the county medical society, state medical association, and AMA and would urge all Hawaii physicians to belong to all three components. The question involved is not one of the value of the AMA and our continued need to fully support it. The question is one of voluntary or mandatory membership. The delegates and officers of this House are charged with making decisions for the membership based on what they, as involved, informed, concerned representatives believe to be in the best interest of the organizations and its members. However, there are instances in which this decision-making process cannot merely reflect the personal opinions of the members of the House, but must take into consideration the majority opinion of the members of HMA as a whole, if such a majority opinion has been ascertained prior to the meeting of the House. To disregard a documented majority opinion would seem to suggest a lack of responsiveness to the members' wishes, or a paternalistic attitude toward the members by the House. Your Reference Committee, therefore, recommends that the proposed bylaws changes as presented be adopted.

HOUSE ACTION:
Adopted amendments 2.01 and 2.085, by vote of 39 (in favor) to 16 (against), as follows:

a. Amend Section 2.01 as follows: "Every member in good standing of a component society of this Association shall be a member of this Association, either as an active, special, or service member, and MAY BE A MEMBER OF the American Medical Association. Membership in the Hawaii Medical Association or in any of its component societies shall not be denied or abridged on account of color, creed, race, religion, sex, CITIZENSHIP, or ethnic origin."
b. Editorial change in Section 2.085: "All members of the Association ~~shall~~ MAY be either active or special members of the American Medical Association. The Secretary of this Association shall certify the members for enrollment in the American Medical Association.

The President pointed out that since the bylaws do not stipulate an effective date for such amendments, the amendments adopted at this Special Meeting will take effect immediately.

The President also expressed his appreciation to all members of the House of Delegates for devoting their time to consider these important issues.

The meeting adjourned at 3:50 p.m.

KWONG YEN LUM, M.D.
Secretary

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Minutes of Meeting
Friday, April 3, 1981
320 Ward Avenue

PRESENT:

Drs. Winn, Catts, Lum, Hindle, Chinn, Iaconetti, Fong, Wasson, Wentworth, Bade, Chun-Hoon, Lumeng, Goto, Bruce, Cahill, Simmons, Wigle, Fu, Sia, Chang, Dang, Hall, Mr. V. Thomas Rice, Mmes. May Kim and Gwen Fu. Staff present were: Messrs. Won and Jones; Mmes. Kendro, Wong, and Chang.

CALL TO ORDER:

The meeting was called to order by President Winn at 6:05 p.m.

MINUTES:

The minutes of the previous meeting were approved as amended.

REPORT OF THE SECRETARY:

Council reviewed the Report of the Secretary as of March 31, 1981 which indicated that membership totaled 938 as compared with March 1980 when membership totaled 925.

REPORT OF THE TREASURER:

The February 28, 1981 financial statement was reviewed in detail and filed subject to audit. The Treasurer reported that approximately 15 percent of the membership has not submitted dues for 1981. Council requested that staff provide figures on the number of members who have paid 1981 dues in full vs. those who have selected the installment payment plan for report at the next meeting. Council also requested that all counties be provided with a listing of members whose dues are delinquent including those who have not completed their installment payments.

REPORTS OF COMMITTEES AND COMMISSIONS

A. *Public Health:*

Cancer—On behalf of the Cancer Committee, Dr. James Lumeng recommended that HMA sponsor an application to the National Cancer Institute (in response to RFP. No. NCI-CM-17389-26) for a project entitled, "Therapy of Patients with Early Stage Colon and Rectal Cancer." The project would involve the participation of local institutions interested in gastric, pancreatic, and colonic cancer. The Committee rec-

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ommended that Dr. Thomas Hall be the Principal Investigator of the proposed project and that the PHRI staff be utilized to assist in preparation of the grant application. While PHRI had originally planned to submit a competing grant, it was felt that both organizations could work in a cooperative effort with HMA as the sponsor and PHRI as subcontractor in the event that a grant is awarded. PHRI representative, Dr. Fred Gilbert, outlined the basics of an agreement between PHRI and HMA for response to the RFP. It was noted that proposal preparation costs of up to $2,000 would be shared by both organizations if a grant is not awarded, or not submitted. The deadline for receipt of the proposal in Maryland is April 13, 1981.

ACTION:

It was moved, seconded, and passed that HMA proceed with sponsorship of the GI Tumor Study proposal, with a combined ceiling of $2,000 to be shared by HMA and PHRI.

B. *Bureau of Research and Planning & Auxiliary:* Dr. Calvin Sia reported that the Bureau reviewed the recommendations of the Auxiliary's Long Range Planning Committee as directed by Council. Auxiliary President, Mrs. May Kim, reported that the recommendations will be presented for a vote at their annual convention in May. The most important aspects of the recommendations involve: (1) voluntary national Auxiliary membership for a doctor's spouse beginning in 1982, (2) formation of a special membership committee to recruit and retain national membership, (3) restructuring of the HMA Auxiliary's Council to consist of 5 members (instead of current 20+ members), and (4) uniform administrative and fiscal year for all county auxiliaries and state auxiliary Jan. 1-Dec. 31). Mrs. Kim requested that Council consider an assured allotment of approximately $4,000 annually for a 3-year period and that HMA conduct a thorough re-evaluation of the HMA Auxiliary in 1984. Council noted that it cannot commit funds which would be expended in future fiscal years. On behalf of the Bureau, Dr. Sia recommended that HMA support the continued existence of the Auxiliary under their proposed plan.

ACTION:

It was moved, seconded, and passed that HMA support the continued existence of the Auxiliary under their proposed plan, that future Councils and House of Delegates be urged to continue future support of the Auxiliary as requested, and that the Bureau of Research and Planning conduct a re-evaluation of the Auxiliary in 1984 for report to Council.

The Bureau also recommended approval of proposed guidelines for additional component societies within a single county of the State, for presentation to the HMA House of Delegates. The Bureau further suggested that Council recommend to the HMA House of Delegates, a modified bylaws amendment 1.03 concerning additional component societies.

ACTION:

It was moved, seconded, and passed to adopt the proposed guidelines for recommendation to the HMA House of Delegates.

ACTION:

It was moved, seconded, and passed to recommend the modified bylaws amendment 1.03 to the HMA House of Delegates.

C. *Legislation:* Commissioner, Dr. George Goto, briefed Council on the status of pending health legislation. Council discussed the provisions of HB 934, SD1 which proposes changes in the composition of the Board of Medical Examiners. Board member, Dr. Albert Chun-Hoon, stressed the need for HMA to submit nominees for the Board of Medical Examiners on a regular basis.

D. *Health Service and Care:* The President reported that HMA frequently receives requests for support of certificate of need applications from various organizations. The President requested Council's guidance in responding to such requests. A suggestion was made that HMA establish a policy regarding certificate of need support requests.

ACTION:

It was moved, seconded, and passed to refer this matter to the Commission on Health Service and Care.

Dr. Winn reported that the joint statement of the HMA and John A. Burns School of Medicine regarding the size of the medical school and residency training programs will be disseminated to the membership in the near future.

E. *EMS:* Mr. Jon Won reported that the HMA-EMS legal counsel has received a response to his recent letter regarding the Ethics Commission Opinion No. 416. The Ethics Commission responded that the State Ethics Code was not applied to HMA and therefore HMA is not considered a party to the matter. HMA-EMS is continuing to explore its possible course of action.

Council also discussed possible expansion of the EMS Executive Board. A motion to expand the EMS Executive Board to include 7 voting members with 5 HMA representatives, 1 HAH representative, and 1 DOH representative died for lack of a second.

ACTION:

It was moved, seconded, and passed to defer action on possible expansion of the EMS Executive Board until the Ethics Commission issue is settled. There was one opposing vote.

F. *Jail Health Project:* Dr. Walter Chang reported that the State has advertised for a part-time physician position at Oahu Community Correctional Facility. Mrs. Kendro will attend a meeting of jail health project coordinators in Chicago in May.

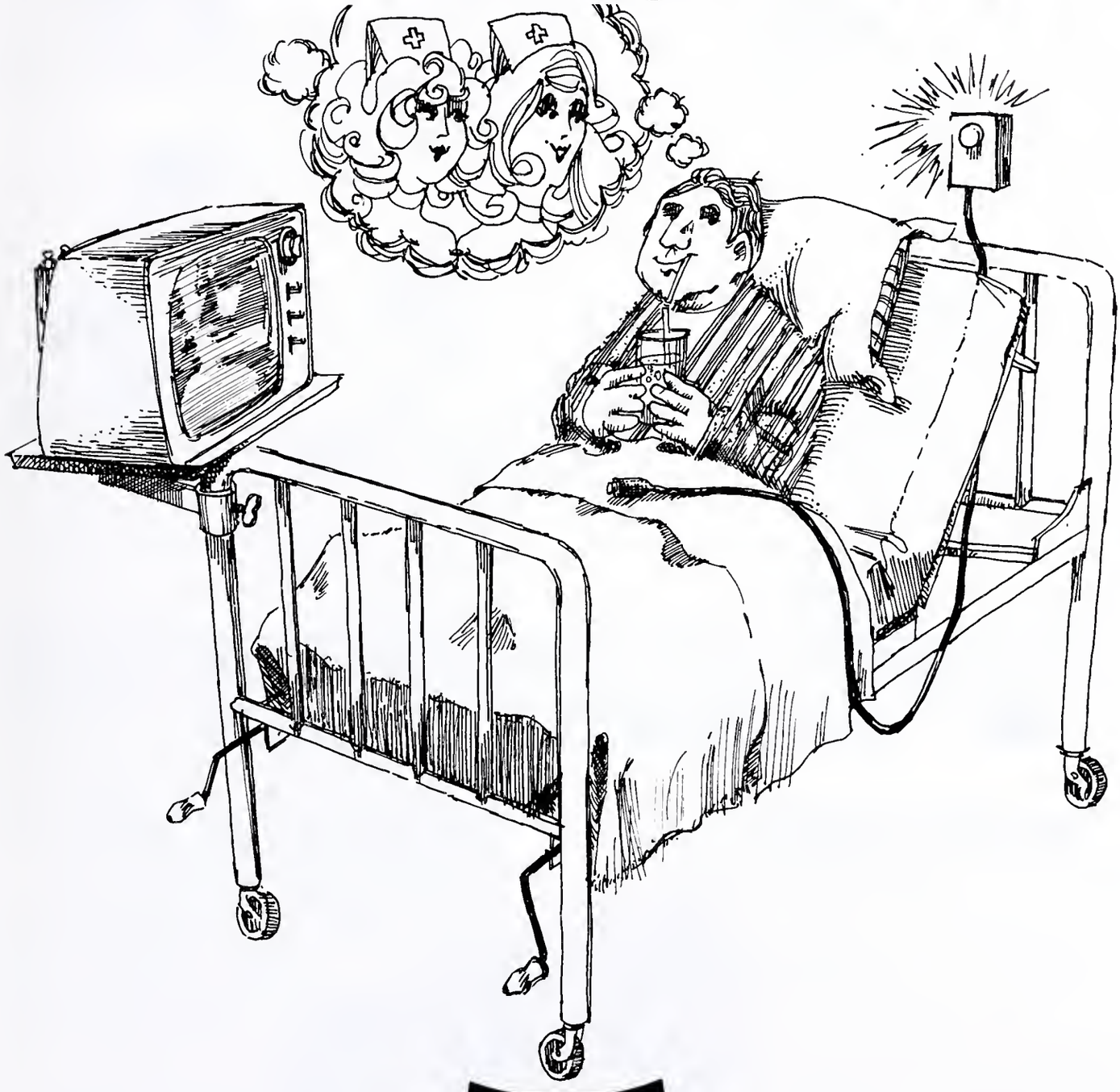
G. *Building:* Mr. Jon Won reported that the Suzanne Stevens Weight Loss Clinic, Inc. has offered to lease a portion of Suite 205 in the HMA building.The lease rent will be $1.25 per square foot per month, and HMA has agreed to paint the office and install new carpets. HMA has inserted two special conditions in the lease which would provide: (1) that if the tenant utilizes weight loss practices that HMA determines are not acceptable to the Association in its sole discretion, then HMA can terminate the lease within 30 days, and (2) that the tenant cannot utilize the name of the HMA or HCMS in advertising their location.

REPORTS OF COUNTY SOCIETY PRESIDENTS

A. *Honolulu:* Dr. Henry Fong reported that HCMS will hold its next membership meeting on April 7. The program will feature a legislative update by Dr. Douglas Bell and discussion on the unit rule issue by panelists, Dr. George Mills and Patrick Walsh.

B. *Maui:* Dr. Eugene Wasson reported that Maui

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Hawaii Medical Service Association

County held its last membership meeting on March 17 with guest speakers, Dr. Neal Winn and Mr. Jon Won. The program focused on legislative efforts, upcoming special meeting of the HMA House of Delegates, and a preview of the HMA's new recruitment slide presentation.

C. *Hawaii:* Dr. Ernest Bade reported that Hawaii County met on February 27 with presentation by Dr. Ralph Hale on the topic of the female athlete. The Society recently conducted its own survey on the unit rule issue.

D. *Kauai:* Dr. Mark Wentworth reported that the Society's next meeting is tentatively scheduled for May 15.

OTHER BUSINESS

A. *Auxiliary:* Mrs. May Kim introduced incoming Auxiliary President, Mrs. Gwen Fu. Auxiliary representatives met with the HMA Bureau of Research and Planning to discuss the recommendations of the Auxiliary's Long Range Planning Committee. (see Bureau of Research and Planning for more details)

B. *Civil Investigative Demand:* Mr. Jon Won reported that HMA has received a civil investigative demand from the State Attorney General's office asking the HMA to turn over any documents concerning Association policy on midwives and their practice, and on any agreement with the medical school regarding the supervision of housestaff. HMA is complying with the request.

C. *Peer Review:* The President reported that he has received a letter from a neighbor island physician concerning medical records in a hospital peer review setting.

ADJOURNMENT

The meeting was adjourned at 9:00 p.m.

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The Nose of the FDA Camel is Under the Tent of The MD!

The Federal Food and Drug Administration has publicly stated that they are not in the business of telling a physician what he may or may not give his patients. Inasmuch as they ARE in the business of preventing the manufacture or importation of drugs they are not yet sure are effective and (!) harmless, their statement is of course not wholly true. Until recently, however, physicians have been free to use drugs that are available for whatever purposes they consider in their patients' best interest. Thus does medicine progress.

For example, though dapsone (Avlosulfon) has never had FDA approval for anything but leprosy until its very recent approval for dermatitis herpetiformis, it has been used for the latter for 15 or 20 years. For at least a decade, it has been widely used for leucocytoclastic vasculitis, as well; indeed, it is probably the best drug for that purpose, and we can and do use it there—without FDA approval, but with their tacit consent. So far!

Japanese investigators[1] found out a few years ago that DMSO denatures, and permits mobilization of, amyloid, in systemic amyloidosis and perhaps in cutaneous (macular or lichenoid) amyloidosis as well. DMSO has FDA approval for a specific use, the symptomatic relief of interstitial cystitis. It is marketed as a 50% aqueous solution, Rimso-50, by Research Industries Corporation. You are permitted to prescribe it—but only for use in the bladder!

A Honolulu pharmacist, asked to fill a prescription for Rimso-50 for topical use on a small skin lesion (of macular amyloidosis), to be labelled "Rub into affected areas twice a day," apologetically declined to fill it except by sending it to the doctor, to be given by him to the patient—because the FDA had not approved this route of administration.

This goes beyond protection. It is gratuitous and unwarrantable interference, and likely to do far more harm than good. The camel's nose is under the tent, and the whole animal is no doubt on the way!

HLA Jr.

FOOTNOTE:

1. Bonnetblanc JM, et al: Dimethyl sulfoxide and macular amyloidosis. Acta Derm Venereol 60(L):91, 1980.
 Ohasi et al: Treatment of primary systemic amyloidosis with dimethyl sulfoxide. Ann Rep Ministry of Health & Welfare Amyloid Neuropathy Research Committee, Dept. Dermatol., Nagoya University, Japan, 1978.

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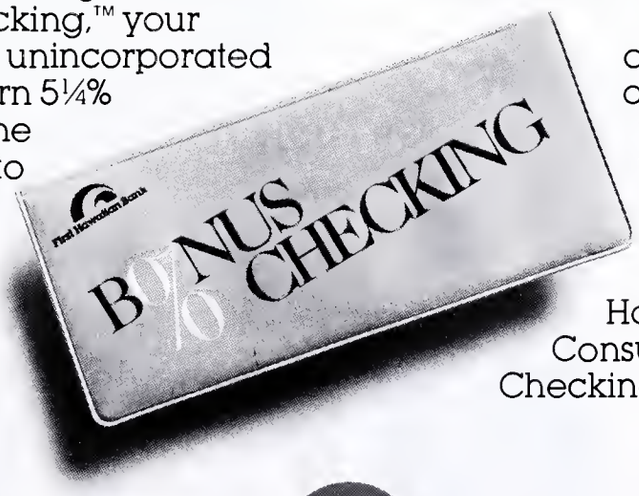


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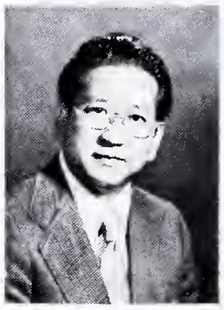
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Methacholine Response in Asthmatics in Hawaii

DOUGLAS G. MASSEY, M.D., M.Sc., F.A.C.P.,* *and* G. GISELE FOURNIER-MASSEY, M.D., Ph.D.,** *Honolulu*

Correspondence and reprint requests to: D.G. Massey, M.D., Kuakini Medical Center, 347 N. Kuakini Street, Honolulu, Hawaii 96817.
Supported by a Grant from the Hawaii Thoracic Society.
Accepted for publication, September, 1980.

• *Mortality from asthma in Hawaii is 3 times and morbidity is 10 times that of mainland U.S.A.*[1,2] *The causes for this are not known. One postulate is imprecise diagnosis. We report here the use of the methacholine test*[3,4] *to test this hypothesis in 25 subjects: 14 asthmatics and 11 controls.*

A total of 25 subjects were selected to form 4 groups; out-of-state asthmatics and controls; Hawaii asthmatics and controls. Asthmatics were obtained from among patients of a private pulmonary practice. Controls were recruited from volunteers from the community. Hawaii asthmatics and controls were defined as those individuals residing in Hawaii for longer than 10 years (Table I).

All subjects signed a consent form, answered a modified respiratory questionnaire[5], an allergy questionnaire (developed by the authors as part of an ongoing project on host and environmental factors of asthma in Hawaii), had a physical examination (D.G.M.), and volumes and flows were determined by an M.D. technologist on a Collins module. (Warren E. Collins, Inc., Braintree, MA 02184). Calculations were verified by G.F.M. Normal values were those of Goldman and Becklake[6] for lung volumes; Needham[7], and Bates et al[8] for mixing efficiency; and of Cotes et al[9] for flows.

The methacholine test of Chai et al[4] was used. Equipment included a Rosenthal-French dosimeter, Model D-2A, (Richard R. Rosenthal, Johns Hopkins University, School of Medicine, Good Samaritan Hospital, 5601 Loch Raven Boulevard, Baltimore, MD 21239), and a DeVilbiss 646 nebulizer, No. 642 nebulizer no longer being produced, (De Vilbiss Health Care Division, Somerset, Pennsylvania 15501). Methacholine (J.T. Baker, 222 Red School Lane, Phillipsburg, N.J. 08865) was prepared as needed by the hospital pharmacist and final dilutions were made in the laboratory just prior to use.

When subjects returned for the methacholine challenge, usually within 7 days of pulmonary function testing, they had been without bronchodilators for 24 hours. An intradermal injection of 0.1 ml of a 0.01 mg/ml histamine solution was placed with a tuberculin syringe, using a 25 gauge needle, into the ventral surface of the left forearm, following Rosenthal[10], instead of Chai's recommended 0.02 ml and a 26 gauge needle. The reaction was read after 20 minutes. A positive reaction was a wheal greater than 5 mm in diameter. The subject then performed 3 FVC curves and, if this "baseline" $FEV_{1.0}$ was within 10% of the value of the previous routine flows, the test was continued.

The subject then inhaled 5 breaths of 0.9 N saline followed in 1½ minutes and 3 minutes by "control" FVC determinations, to which the effects of methacholine were compared. If the control $FEV_{1.0}$ was within 10% of the baseline $FEV_{1.0}$, the subject was challenged with 5 breaths of the first dilution of methacholine. Within 1½ minutes, the FVC was repeated. If the $FEV_{1.0}$ decreased by more than 20% of the control value, the FVC was repeated at 3 minutes. If the $FEV_{1.0}$ remained 20% lower than the control values, the test was interpreted as positive. If the decrease was less than 20% at 1½ minutes or 3 minutes, the subject continued with the next dilution of methacholine using the following increments:

0.15, 0.31, 0.62, 1.25, 2.5, 5.0, 10.0 and up to 25.0 mg/ml. The data were expressed in methacholine inhalation units, with 1 methacholine inhalation unit being equal to 1 inhalation of a 1 mg/ml solution of methacholine in saline diluent.

Immediately following a positive test, 2 breaths of Bronkometer (Isoetherine Mesylate 0.61% (w/w), with saccharine, menthol, alcohol 30% (w/w) and fluorohydrocarbons as gaseous propellant, preserved with ascorbic acid 0.1 (w/w). Breon Laboratories, Inc., manufactured by Sterling Drug, Inc., New York, N.Y. 11061), were administered followed by FVC in 10 minutes.

Results

The number of subjects in each group, number of years they had lived in Hawaii, their sex, mean age, mean height, and smoking habits are shown in Table 1. No significant differences were found between the respective groups as to age, height and weight. Males and females were not evenly distributed among the groups. The Hawaii controls did contain one fewer smoker than the other groups.

Baseline volumes and flows expressed in percent of predicted values are listed in Tables 2 and 3 for all subjects. Vital capacity (VC), Residual volume (RV), Total Lung Capacity (TLC) and Functional Residual Capacity (FRC) are within normal limits of ± 20% of predicted values for all groups. The Forced Vital Capacity (FVC), the indirect Maximal Voluntary Ventilation (MVV), the Forced Expiratory Volume in one second expressed as a volume ($FEV_{1.0}$) and as a ratio of FVC ($FEV_{1.0\%}$), and the Forced Expiratory Flow (FEF_{25-75}) are also within normal limits, except in Hawaii asthmatics, in whom the $FEV_{1.0}$ is low borderline and the FEF_{25-75} is 56%. It should be noted that the normal range for FEF_{25-75} is ± 35% of predicted because it is very sensitive. The change in flows after inhalation of saline aerosol (control) compared to baseline values (street levels) is not significant ($p>0.5$) (Table 4).

The methacholine challenge is summarized in Table 5 as the cumulative dose of methacholine, the duration of the test, the dose of methacholine per minute to cause a fall of 20% in the $FEV_{1.0}$ (PD_{20}-$FEV_{1.0}$), and the percentage changes in $FEV_{1.0}$ and FEF_{25-75} for each group. The results of the asthmatic group are given for the group in toto (all) as well as for the reactors ie, positive test (+) only.

The asthmatic group show significantly greater reductions in $FEV_{1.0}$ and FEF_{25-75} than controls. Bigger reductions were noted in FEF_{25-75} as compared to the $FEV_{1.0}$, especially the out-of-state asthmatics. The Hawaiian asthmatics were relatively insensitive to Methacholine requiring 4 times as many units for less change in flows.

Discussion

The methacholine test is a useful diagnostic

TABLE 1.—*Characteristics Of Subjects*

GROUP	SUBJ. NO.	YEARS IN HAWAII	SEX M	SEX F	AGE (YRS.) MEAN±S.D.	HEIGHT (CM.) MEAN±S.D.	WEIGHT (KG.) MEAN±S.D.	SMOKERS
Control								
Out of State (OSS)	5	<5	4	1	28±17	174±11	65± 9	2
Hawaii (HI)	6	Life (4) >20 (2)	1	5	28± 4	159± 9	59±14	1
Asthma		<5 (5)						
Out of State (OOS)	6	<10 (1)	1	5	32± 8	164± 8	62±18	2
Hawaii (HI)	8	Life (7) >18 (1)	5	3	31±17	162±10	67±14	2

TABLE 2.—*Pulmonary Function Tests - Baseline Volumes*

GROUP		VC % PREDICTED	RV % PREDICTED	TLC % PREDICTED	FRC % PREDICTED
Control	OOS	106 ± 21	106 ± 25	114 ± 27	108 ± 29
	HI	102 ± 13	100 ± 23	102 ± 13	100 ± 19
Asthma	OOS	98 ± 14	99 ± 40	98 ± 16	89 ± 28
	HI	93 ± 23	104 ± 21	96 ± 18	96 ± 20

TABLE 3.—*Pulmonary Function Test - Baseline Flows*

GROUP		FVC % PREDICTED	MVV % PREDICTED	FEV1.0 % PREDICTED	$FEV_{1.0\%}$ % PREDICTED	FEF_{25-75} % PREDICTED
Control	OOS	104 ± 19	115 ± 16	110 ± 12	108 ± 12	121 ± 36
	HI	103 ± 9	117 ± 9	107 ± 6	106 ± 7	99 ± 9
Asthma	OOS	98 ± 13	115 ± 16	107 ± 13	109 ± 11	95 ± 21
	HI	92 ± 23	81 ± 26	79 ± 23	88 ± 12	56 ± 27

aid in asthma. It is included in the definition of asthma by European authors.

Although the subjects were not matched, they were similar in age, height, weight, smoking history, and length of stay in Hawaii. The sex distribution of the subjects was different in the groups. The pulmonary function results were compared to the predicted values for age, sex, and height and each individual served as his own control.

The volumes and flows of the control groups were within normal limits, although the range exceeded the ± 20% usually predicted. This was particularly true for the out-of-state group. As the techniques, equipment, and technologist were constant, the choice of subjects may have been responsible. Many from out-of-state come to Hawaii for the outdoor life and are perhaps more physically fit.

The volumes and flows of the asthmatics were within normal limits except for a borderline reduction in $FEV_{1.0}$ and FEF_{25-75} of those from Hawaii. The range of the latter group was also greater, suggesting that this group included individuals who were or could have been more ill. A further factor which is operative is that normal values for Hawaii residents are not known. Normal Americans of Japanese descent have significantly different pulmonary function than do Americans of European ancestry."

The inhalation of saline did not alter the baseline pulmonary function results significantly indicating that subsequent alterations were due to methacholine.

A cumulative dose of 599 methacholine units resulted in an 11% or less change in $FEV_{1.0}$ and 25% or less change in the FEF_{25-75} of the controls. By contrast, less than half that amount in a shorter time decreased the $FEV_{1.0}$ more than 20% and FEF_{25-75} over 30% in the asthmatics.

However, 2 unexpected findings appeared. 1.) 4 of the 14 asthmatics did not respond, and 2.) the methacholine responders among the asthmatics long resident in Hawaii were surprisingly resistant to methacholine.

The finding of non-responders among the asthmatics lends support to the hypothesis that misdiagnosis may be responsible for some of the morbidity and mortality from asthma in Hawaii. However, it cannot be the entire explanation, as 2 of the asthmatics from the mainland also did not respond.

The finding of relative resistance to methacholine of the asthmatics from Hawaii was totally unexpected and cannot easily be explained. They required 62.4 methacholine units to decrease their $FEV_{1.0}$ by 29%, compared to the 15.2 units for out-of-state asthmatics. Furthermore, the FEF_{25-75} in the former group fell only 33.9%, compared to 57.7% in the latter.

One possible explanation is a significant variation in delivery of the methacholine. Although the Rosenthal-French dosimeter is designed to minimize this problem, even the subjects noted a significant inter- and intra- nebulizer variation. The latter varies with cleaning and sterilization procedures, the very critical position of the jet, the amount of fluid at the bottom of the nebulizer and the inspiratory volume[12]. It is possible that the differences in inspiratory volume could favor one asthmatic group. The asthmatics from Hawaii had smaller vital capacities, $FEV_{1.0}$ and FEF_{25-75} thus taking a smaller volume each breath and retaining less methacholine.

The alternative explanation has serious implications, in that it could be considered that the basis of asthma in these patients is not the autonomic imbalance considered to underly asthma. Should this be so, the heavy reliance on sympathicomimetic drugs and hopes for parasympatholytic drugs such as atropine analogues needs re-examining. More emphasis would be placed on therapy with the

TABLE 4.—*Variations from Baseline Flow Values After Inhalation of 5 Breaths of Saline*

GROUP		FVC		MVV		$FEV_{1.0}$		$FEV_{1.0\%}$		FEF_{25-75}	
		BASELINE L	SALINE ∇%	BASELINE L/MIN	SALINE ∇%	BASELINE L/SEC.	SALINE ∇%	BASELINE %	SALINE ∇%	BASELINE L/SEC.	SALINE ∇%
Control	OOS	4.98	+1.2	150.1	−0.2	4.20	+0.5	85.3	−10.8	4.81	−3.7
	HI	3.56	+0.4	110.3	+0.1	3.11	+1.3	89.1	+0.7	3.77	−1.1
Asthma	OOS	3.47	−0.2	101.2	+1.9	2.80	−0.3	82.8	−0.7	3.13	−4.0
	HI	3.37	+1.4	92.9	+2.2	2.59	+0.1	74.2	−0.5	2.23	+0.6

TABLE 5.—*Correlation of Methacholine Units with Change in Flows*

GROUP	METHACHOLINE (CUMULATIVE) UNITS	TIME MIN.	$PD_{20}FEV_{1.0}$ UNITS/MIN.	$FEV_{1.0}$ SALINE L/SEC.	$FEV_{1.0}$ METHACHOLINE ∇%	FEF_{25-75} SALINE L/SEC.	FEF_{25-75} METHACHOLINE ∇%
Control							
OOS	599.2	58.5		4.40	−11.2	4.64	−25.8
HI	599.2	68.0		3.26	−10.1	3.62	−23.5
Asthma							
OSS (All)	209.0	44.3	4.8	2.98	−23.7	3.07	−44.0
(+)	15.2	32.0	0.5	2.67	−29.7	3.14	−57.7
HI (All)	196.6	42.6	4.6	2.49	−21.1	2.24	−30.2
(+)	62.4	34.0	1.8	2.34	−29.3	2.05	−33.9

theophylines and corticosteroids.

Summary

Mortality from asthma in Hawaii is 3 times and morbidity 10 times that of mainland U.S.A. The explanation is unknown, but imprecise diagnosis could be responsible. The addition of methacholine inhalation challenge to the diagnostic process could clarify this point. The presence of methacholine reactivity was determined in 14 asthmatics and 11 controls among long and short term residents of Hawaii. Of the asthmatics, 4 were unresponsive: 2 long-term and 2 short-term residents, Furthermore, the reactive long-time resident asthmatics responded only to significantly more methacholine units than recent arrivals. All control subjects were unresponsive to methacholine challenge.

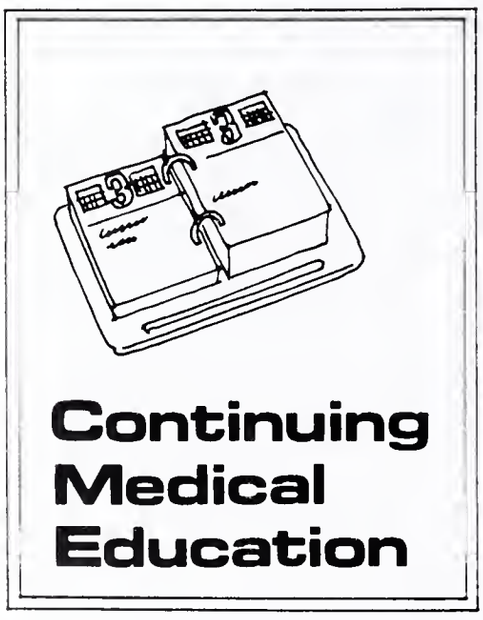
Acknowledgements

The administrative assistance of Ms H. Araki, R.N. is most gratefully acknowledged.

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CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, First Thursday, 12:45 p.m. and Fourth Tues. 12:30 p.m. w/Maui Mem. Hsp. Held on Oahu at Am. Cancer Society main conf. room, 200 N. Vineyard, Honolulu.

John A. Burns School of Medicine

1. Dept of Medicine
 - A. Case Conferences, Second and Fourth Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 - B. Grand Rounds, First and Third Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 - C. Endocrinology Grand Rounds, Third Wednesdays, 5:30-6:30 p.m., Queens University Tower, Room 506.
 - D. Hematology Grand Rounds, Second and Fourth Mondays, 12:30-1:30 p.m., Queens University Tower, Room 721.
 - E. Cardiology Grand Rounds, First and Third Tuesdays, 5:30-6:30 p.m., Queens University Tower, Room 508.
 - F. Infectious Disease Grand Rounds, Second and Fourth Tuesdays, 5:00-6:00 p.m., Queens Nalani I Conference Room.
 - G. Dermatology Grand Rounds, Second Wednesday, 7:30-8:30 a.m. Queens, Queen Emma Clinic.
 - H. Pulmonary Grand Rounds, Second and Fourth Thursdays, 4:30-5:30 p.m., Queens Kamehameha Auditorium.
2. Division of Nuclear Medicine
 - A. Technical aspects of Nuclear Medicine, Second Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506, 1½ credits.
 - B. Rounds, Fourth Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506.
3. Dept. of Obstetrics and Gynecology
 - A. Grand Rounds, Wednesday 7:30-8:30 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.

4. Division of Orthopaedics
 A. Fracture Conference, Tuesdays, 5:00-6:00 p.m., Queens University Tower, Room 618.
 B. Shriners Hospital Conference, Tuesdays, 7:15-9:15 a.m., Shriners Hospital.
5. Dept. of Pediatrics
 A. Grand Rounds, Thursdays 8:00-9:00 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 B. Pediatric Conference, Mondays 12:45-1:45 p.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 C. Pediatric Infectious Disease Conference, Thursdays, 12:30-1:30 p.m., Kapiolani-Children's Medical Center, Third Floor Conference Room.
 D. Neonatal Ground Rounds, Fridays, 8-9:00 a.m., Kapiolani-Children's Medical Center, Administrative Conference Room.
6. Dept. of Psychiatry
 A. Grand Rounds, Fridays 8:00-9:30 a.m., Queens University Tower, Room 618.
7. Dept. of Surgery
 A. Grand Rounds, First, Second and Third Saturdays, 7:30-9:00 a.m., rotating hospitals.
 B. Statistical M and M, last Saturday, 7:30-9:00 a.m., rotating hospitals.
 C. Journal Club, First and Third Tuesdays, 6:00-8:00 p.m., Queens University Tower, Room 620.
 D. Medical-Surgical G.I. Rounds, Second Tuesday, 7:00-8:00 a.m., Queens University Tower, Room 506.
8. Depart of Family Practice
 A. Conf., Wednesdays, 8-9:00 a.m. Kaiser 4th Floor Conf. Room.
 B. Conf., Thursdays, 12-1:00 p.m. Kaiser 4th Floor Conf. Room.
9. Department of Physiology
 A. Dept. Conf., Wednesday, 4:30-5:30 p.m. BioMed T-210.
10. University of Hawaii, John A. Burns School of Medicine Grand Rounds, Third Thursday, 4:30-6:00 p.m., Queen's University Tower, Room 618 or BioMed Building.
11. H1 Oncology Group, one Monday a mnth., 12:30-1:30 p.m., The Cancer Center, 1236 Lauhala St., 4th Floor Conference Room.

Federation of Emergency Medicine-Maui

1. **Cardiology for the Emergency Physician.** Every Monday, 9-10:00 a.m.-Maui Memorial Hsp. Conf. Rm #1. (For spec. topics or further info. contact: Federation Office (808) 244-7629, or Dr. C. T. Mitchell, (808) 244-9056.
2. **Journal Club in Emerg. Medicine.** 2 hrs. Cat. 1. MMH Conf. Rm. #1. 9am-11 a.m.
 7/20/81 Annals in Em Med, 3/81; Abstracts in EM 4/81 - C. Mitchell
 8/24/81 Annals in Em Med, 4/81; Abstracts in EM 5/81 - D. King
 9/21/81 Annals in Em Med, 5/81; Abstracts in EM 6/81 - S. Burkle
 10/19/81 Annals in Em Med, 6/81; Abstracts in EM 7/81 - P. McCallum
 11/23/81 Annals in Em Med, 7/81; Abstracts in EM, 8/81 - J. Mills
 12/21/81 Annals in Em Med, 8/81; Abstracts in EM, 9/81 - C. Mitchell

Hawaii Thoracic Society

1. Pulmonary Med., Clinical case presentations & current research in pul. med. with U of H Sinclair Chest Club. Third or Fourth Wed., ea month, 7:30 p.m.-9:30 p.m. For further info contact: Rosemary Respicio, B.S.N. at (808) 537-5966.

Hickam Clinic

1. Clinical Correlation Conference, First Thursday, 11:00 a.m.
2. Didactic—our staff, Second Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, Third Thursday, 11:00 a.m.
4. Radiology Conference, Fourth Thursday, 11:00 a.m. (Contact Aurora Macapinlac, M.D., M.C., 449-5770)

Hilo Hospital

1. Orthopedic Conference, First Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, Second Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, Third Friday, 12:30-1:30 p.m.
5. C.P.C., Second Friday, 12:30-1:30 p.m.
6. Visiting Professor's Program

Kaiser Hospital

1. Medicine Grnd. Rnds. Every Tues. 8 a.m. Pac. Aud. 1 hr. Cat. 1.
2. Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. 1.
3. OB/Ped. Perinatal Mortality Conf. Last Tues. ea. mnth. 8:00 a.m. 1 hr. Cat. 1.
4. Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. 1.
5. Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. 1.

(Contact CME Dept.-Kaiser for further information)

Kapiolani-Children's Medical Center

1. Pediatric Grnd. Rnds. Every Thursday, 8-9:00 a.m. Aud.
2. Pediatric Conf. Mondays, 12:45-1:45 p.m. 2nd Floor Aud.
3. Neonatal Grnd. Rnds., Fri. 8-9:00 a.m., Conf. Rm. B.
4. Pediatric Infectious Disease Conf., Thursdays, 12:30-1:30 p.m. 3rd Floor Conf. Rm.
5. Ob-Gyn Conf. Tues. 1-2:00 p.m. Aud.
 First—Didactic Presentation
 Second—Perinatal-Neonatal Topics
 Third—Obstetrics Topics
 Fourth—Gyn Topics
6. Tumor Brd.—Oncology Conf. First and Third Fri. 1-2:00 p.m., Aud.

Kuakini Medical Center

1. Department of Ophthalmology Mtg., First Tuesday, 12:30-1:30 p.m.
2. Department of Medicine Mtg. (Statistical), Fourth Tuesday, 1:00-2:00 p.m.
3. G.I. Conference, First Tuesday, 8:00-9:00 a.m.
4. Nephrology Conference, First Wednesday, 8:00-9:00 a.m.
5. Oncology Conference, every Thursday, 7:30-8:30 a.m.
6. Pulmonary Conference, First Thursday, 1:00-2:00 p.m.
7. Surgical Conference Second & Fifth Friday, 12:45-1:45 p.m.
8. Surgical M & M Conference, Fourth Friday, 12:45-1:45 p.m.
9. Department of Medicine Evening Mtg., Second Tuesday, 5:30-7:00 p.m.
10. Visiting Professor Program (for further infor contact CME Dept. 547-9226 as these programs may be subject to change.)

Maui Memorial Hospital

1. Thurs. Conf. 7-8:00 a.m. Staff Dining Rm.
 1st—Dept. of Medicine
 2nd—Dept. of Surgery
 3rd—Dept. of OB/GYN
 4th—Dept. of Pediatrics
 5th—Elective
2. Tumor Brd. every Mon. 12:15-1:15 p.m.—Tumor Conf. Telephone Task Force—Third Tues. 12:15-1:15 p.m.

3. Dept. of Emergency Med., Third Mon., 7-8:00 a.m.
4. Diagnostic Radiology—Fourth Tues., 12-1:00 p.m.
5. SFH-UH Hematology Conf., Third Thursday, 12:30 p.m.Sullivan-4 Classroom.
6. SFH-UH Surgical Grand Rounds, First, Second, & Third Fridays, 7:30 a.m., Sullivan-4 Classroom.
7. Visiting Professor Programs (for further infor call CME office at St. Francis).

The Queen's Medical Center

1. ENT Conferences, First and Second Fridays, 7:30 a.m., Small Dining Room.
2. Medical Conferences, Every Friday, 8:00 a.m., Kam Auditorium.
3. Ob/Gyn Conferences, Second and Fourth Mondays, 1:00 p.m., Kam Auditorium.
4. Ophthalmology Conference, Fourth Tuesday, 5:00 p.m., Queen Emma Eye Clinic.
5. Orthopaedic Conferences, Every Wednesday, 7:00 a.m., Kam Auditorium.
6. Pathology Conferences, Every Wednesday, 7:30 a.m., Surgical Conference Room.
7. Pediatric Grand Rounds, Fourth Thursday, 12:30 p.m., Nalani I Conference Room.
8. Surgical Trauma Conference, Second Tuesday, 4:30 p.m., Kam Auditorium.

 Basic Science Lectures, Every Wednesday, 7:15 a.m., Queen's University Tower, Room 618.

St. Francis Hospital

1. SFH-UH Tumor Conf., Every Monday, 7:30 a.m. Sullivan-4 Classroom.
2. SFH-UH Nephrology Conf., First Monday, 1:00 p.m. Sullivan-4 Classroom.
3. SFH-UH Endocrine Conf., last Monday, 12:30 p.m. Sullivan-4 Classroom.
4. EENT Meeting, First Tuesday, 7:00 a.m., Sullivan-4 Classroom.
5. SFH-UH Hematology Conf., Third Thursday, 12:30 p.m. Sullivan-4 Classroom.
6. SFH-UH Surgical Grand Rounds, First, Second, & Third Fridays, 7:30 a.m., Sullivan-4 Classroom.
7. Visiting Professor Programs (for further infor call CME office at St. Francis).

Straub Clinic & Hospital

1. Straub Professional Seminar meets the Second Tuesday of each month, from 5:00-6:30 p.m. in the Credit Union Meeting Room (2nd Floor, Credit Union Bldg).
2. Surgical Mortality and Morbidity Conference meets every Fourth Thursday of each month, from 7:00-8:00 a.m. in the Doctors' Dining Room.
3. Cardiac Surgery Conference meets the Third Tuesday of each month, from 4:30-5:30 p.m. in the Doctors' Dining Room.
4. Department of Anesthesiology meets the Second Tuesday of each month from 7:00-8:00 p.m. in the Doctors' Dining Room.
5. Community Peripheral Vascular Conference meets the Fourth Thursday of each month from 5:00-6:30 p.m. in the Doctor's Dining Room.
6. Visiting Professor Program meets monthly from 7:00-8:00 a.m. in the Doctors' Dining Room.
7. Urology Inservice meets every other month on the Third Friday from 8:00-9:00 a.m. in the Doctors' Dining Room.
8. Neuropathology Clinical Correlation Conference meets the Third Thursday of each month from 7:30-8:30 a.m. in the Straub Morgue.
9. OB-GYN Pathology meets every Fourth Monday of each month from 12:30-1:30 p.m. in the Administration Conference Room (ACR).
10. Urologic Pathology meets every First Monday of each month from 8:00-9:00 a.m. in the Doctors' Dining Room.
11. Friday Noon Conference meets every Friday of each month from 12:30-1:30 p.m. in the Doctors' Dining Room.

*Note: All conferences are subject to change. Monthly calendar will be available upon request.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday
2. General Medical Staff Meeting—Second Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Miscellaneous

HMA Maternal and Perinatal Mortality Study Cmte. First Monday ea. month-5:30 p.m. 320 Ward Ave., S 200. Cat. 1 on hr. for hr. basis.

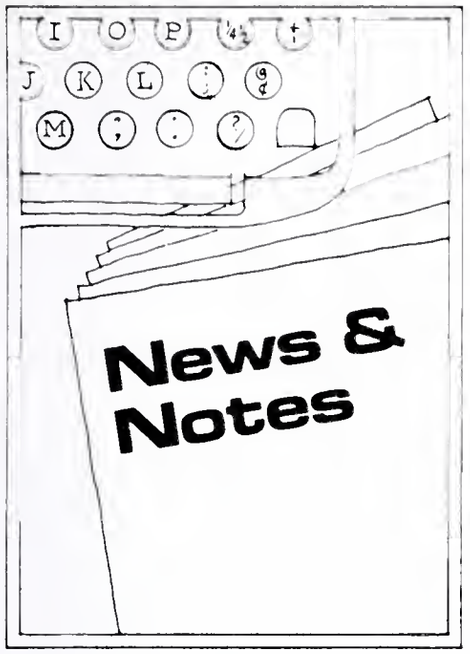
SPECIAL EVENTS

July 11, 18, 1981	Endoctrine Metabolic Crse., U of So. CA Schl of Med., 2025 Zonal Ave., LA, CA 90033. Held: Mauna Kea Beach Htl, Kamuela, HI.
July 22, 29, 1981	Refresher for Technologists & Pathology. USC Schl of Med., 2025 Zonal Ave., LA, CA 90033. Held: Kauai Surf Htl, Kauai, HI.
July 31, Aug 4, 1981	ACP Internal Medicine Update, Spons: ACP & J.A. Burns Schl of Med, Honolulu, Contact: Dee Chang (808) 947-8573. Held: Wailea Beach Htl, Maui.
Aug 7, 8, 1981	Ophthalmology Annual Mtg., Alumni U of CA Irvine Coll. of Med., Irvine, CA. Held: Kona, HI.
Aug 15, 26, 1981	24th Annual Postgraduate Refresher Course, USC School of Medicine in assoc. with TAMC, Honolulu and Maui, up to 37 hours, $375 tuition.
Aug 25, 26, 1981	Gynecological Urology: A Teaching Course, Sheraton-Waikiki, UC Irvine, Jack R. Robertson, 1430 E. Main St., Santa Maria, CA 93454.
Aug 26, Sept. 7, 1981	Third Ann. Radiology for Nonradiologists. San Diego Rad. Res. & Educ Found, Box 2305, LaJolla, CA. 92038; cospons: Am Col of Radiology. Held; Kauai Surf Resort Htl, Kauai. 35 hrs. Cat. 1.
Aug 29-Sept 4, 1981	Concepts in Infertility-1981, Royal Lahaina, Maui, Stanley Friedman, The Edward Tyler Medical Clinic, 921 Westwood Blvd., LA 90024.
Oct. 7-9, 1981	"Current Neurology." Straub Clinic & Hsp. Held: Honolulu Art Academy Aug, 900 S. Beretania, Honolulu. Contact: Off. of Med. Admins., Straub, 888 So. King St. Honolulu, 96813; (808) 523-2311.
Oct 12, 16, 1981	Oncology Board Review, Princess Kaiulani, ACP, Dr. Thomas Hall, Cancer Center of Hawaii, 1236 Lauhala, Honolulu 96813.
Oct. 12, 16, 1981	AMA Regional & Scientific Mtg/HMA Annual Mtg. Held: Ilikai Htl, Waikiki. Contact: AMA Dept. of Mtg. Serv.; 535 No. Dearborn St., Chicago, IL 60610.

OUT OF STATE

For information on any out-of-state programs or courses, refer to September 3, 1980 Supplement to JAMA or call the HMA Office.

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HENRY N YOKOYAMA, M.D.

Herb Takaki's Birthday Roast

Herb was worried . . . His 80th birthday was around the corner, but no one seemed to care . . . How was he to know that Gladys, his loving wife had secretly asked **Mike Okihiro** to arrange a birthday roast with his golfing and card playing cronies at Mid Pac CC . . . So roast, they did, but first there was a Takaki Shoot Your Age Tournament arranged by tournament chairman **Limin Kung**. So Herb shot a gross 87-80 for a net 7 and won easily . . . Herb's son, vascular surgeon **Harvey** thanked the group of 50 in behalf of his family and confessed that he had learned three things from his dad . . . How to Swear; How to play golf; and How Not to Gamble!

Herb's accountant, Gilbert Hayashi related how Herb came up to him with the woeful tale that he had somehow lost all the markers from his Sunday morning gambling winnings so all those owing Herb any money were hereby let off the hook . . .

Lionel Furukawa, president of the Sunday morning PGA (Poor Gamblers Association) had voted to put up Herb Takaki for its PGA Hall of Fame . . . It was a unanimous vote . . .

Herb recalled that when he was at the University of Chicago back in 1921, his heroes were Al Capone and Caruso . . . Then he rendered in his operatic baritone which resonated through the large dining room, "When I Grow Too Old to Dream," "Here's To Happiness . . ." and his favorite "Toreador Song" in unadulterated Italian . . .

MC Mike Okihiro then read off the characteristics of a person born in the Year of the Ox . . . To wit, that he is very patient and speaks little . . . He is eccentric and terribly bigoted . . . Yet for all his patience and reticence, there is a paradoxical quality in his temperament . . . He angers easily and shows it . . . It would be wise to avoid an Ox-Year person when he is angry for he is likely to do something rash to anyone confronting him . . . He is remarkably stubborn and he hates to fail at anything he does . . . If he is opposed when he wants to work on a project, his patience may wear thin and he can be quite unpleasant . . ." (How apt the description . . . We are convinced that Herb is the true essence of the Ox-Year person . . .)

Lawyer buddy Mark Murakami was with Herb in Chicago, related how Herb was a man about town, that his name is posted in the U of Chicago wrestling roster and that he was a varsity baseball player. Herb himself says that Kendo was his real forte . . . All this in a healthy 80-year-old who smokes 6 packs of cigarettes a day, drinks a dozen cups of coffee and can drive a golf ball farther with his D6 driver and one eye than youngsters half his age . . . Herb was in 7th Heaven with all the acknowledgments showered him . . . Thus did Herb Takaki, golfer, gambler, rabid cusser, and dear friend celebrate his 80th birthday . . .

But not before Carl Kaizawa of Kaizawa Advertising Agency read the following complaint received by the Mid Pac Country Club president . . .

"MEMO TO: President, Mid-Pacific Country Club

This is a letter of complaint directed to one of your members whose verbal expressions are loud and obscene.

Many of us residents of the Blue Rock Townhouse are God fearing Christians and are terribly disturbed by such heathen outbursts . . .

This person's actions are also a threat to our investment as the value of our property is surely to decline with the slum-like verbal environment that he is creating.

To identify this rascal, I believe he is Japanese as his mannerisms reminds me of our gardener that we had in Vancouver, and also, one of the minor characters that played in the TV series of Shogun. I think he is an American, as his enunciation of the letter "F" is quite distinct.

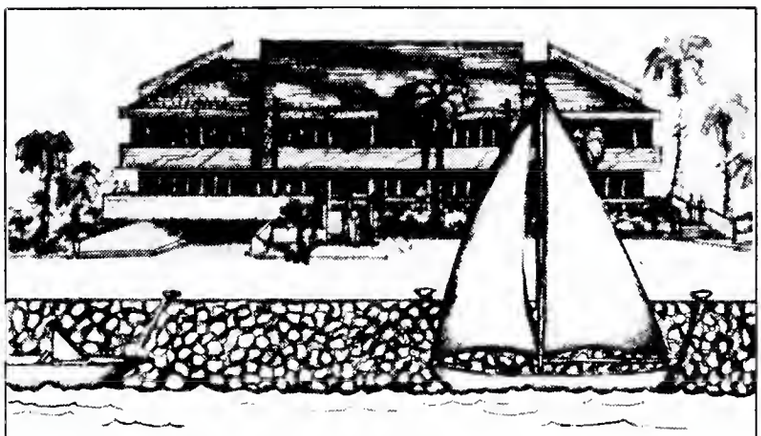
This dastardly person stands about 5 ft. high or so and usually is in a golf attire with colors that are uncoordinated much like his golf swing. He's usually on the golf course in the afternoon on Thursdays and Sundays. The reason I know this is because we have our bible study on those days, and he is definitely heard from T to green.

Your immediate action to remedy this damnable situation will be greatly appreciated by the entire Blue Rock Townhouse Association.

P.S. We will gladly take some photos of this scoundrel is further identification is needed."

Personalities

Durable septuagenerian tennis champ **Yutaka Yoshida:** "If I get a cardiac arrest while playing tennis, don't revive me . . ." What a way to go . . .



Marina/Office space -in Hawaii Kai?

Yes, a waterfront location, one of the most outstanding sites in all Hawaii, is leasing now. Beautiful, low-rise office buildings in a Safeway Supermarket, Longs Drug Store-anchored, quality shopping center will be ready the end of this year. Offices are available from as small as 600 sq. ft. Act now! For more information, call or write Aart Vuyk, KACOR Hawaii Properties, P.O. Box 25007, Honolulu, HI, 96825, 808-395-2331.

Kuapa Kai Center

Another quality project by

KACOR Development Company

A wholly owned subsidiary of Kaiser Aluminum & Chemical Corporation

Surgeon **Roy Tanoue** after hearing medical oncologist **David Plotkin** admit that chemotherapy has made little progress: "That's what I have been saying all along . . ."

Neurologist **Jordan Popper** was told by HMSA that his fees were too high. So he compared notes with fellow neurologists, and discovered to his amazement that his fees were actually lower than those of his colleagues. Says Jordan, "HMSA has such ingrained dishonesty."

We joined **George Kimata** viewing the display of early plantation life in the KMC basement display case. George was attracted by a painting of a cane hauling locomotive . . . George reminisced his childhood on Kauai . . . "That must be Old No. 2 . . . The engineer would shoot steam at us so we would grease the tracks on an upgrade . . . And how he would cuss at us! . . . He had to backtrack all the way back and gather enough speed to make the upgrade . . ."

Runners and Diets: (Extracted from *Star-Bulletin* writer, John Christensen's fine article "Eating on the Run.") Jim Gallup, the "eccentric pathologist" gets 50% of his weekly protein from peanut butter-and-jelly sandwiches. While his family sits down to a sumptuous steak dinner, Jim savors a steaming plate of creamed tuna on toast . . . At 44 Jim is one of the fastest distance runners . . . He runs 100 miles a week, including to and from work, and at lunch time. There is so little fat on his body that in air-conditioned buildings, he wears earmuffs and boots. His 120 lb. physique has only 9% fat . . . Jim admits that his diet is not normal . . .

Jack Scaff says, "Diets are in chaos. Right now, vegetarianism is very popular, but I don't really see that it offers any exclusive benefits over a more rounded diet . . . " It may be that Scaff defends aberrant behavior because he's guilty of it himself. Scaff, confesses to a weakness for beer and "very hot chili. I could live on the stuff."

Thomas Bassler, one of the founding members of the American Medical Joggers Association, takes a lot of vitamins and is said to drink a pint of beer for every 6 miles he runs . . . Jack says, "Tom Bassler said that the 'crave diet' is probably the best for runners . . ." Jack recommends a diet in high fiber and whole foods as opposed to packaged food doctored with additives.

Robert Smith, chief of orthohpedics and sports medicine for the Honolulu Medical Group, "I see eating (and running) as an evolutionary kind of thing . . . Once you get into it, you keep moving away from the harmful toward the good stuff." He eats lots of vegetables and fruits and whole grains. Once or twice a week, he eats a little chicken or fish and drinks beer once every 3 months . . . Breakfast is an inelegant chilled cereal of oats, wheat, barley and rye with seasonings, seeds and raisins, topped with a mixture of apple and lemon juice. (Ugh!)

Marathon Mullah: Jack Scaff, the 44 year old pundit says, "Run for fun (as well as for health). Fun running is indigenous to Oahu." Jack says, "This is the biggest fitness boom in history . . . Running is beneficial to virtually all the organs, not just the heart . . . I can tell you right now that I have not seen a case of bleeding duodenal ulcers in a marathon runner (he used to have one before running) nor have I seen a case of acute gall bladder, or diverticulitis, or anyone who's required an appendectomy . . . These are all disease of urban civilization." (Excerpts from *Advertiser* columnist Carol Hogan's article.)

Kids and the marathon: (From *Advertiser* columnist Mike Tymn's article)

Pediatrician **Fernando Atienza,** father of Dawn Atienza, last year's Honolulu Marathon winner in the girl's-12-and-under category, feels that running is natural for children and that the child is better suited for endurance events than speed. The only limiting factor is a psychological one in that the child does get disinterested and will run only if it is fun, if it enables him to express himself and if in return gets encouragement and praise. Cardiologist **Hunky Chun,** one of the "Hunky Bunch," says he is not in favor of excessive nonaerobic type training for small children, but sees no problems in aerobic (endurance) running. "As long as they enjoy it, let them do it . . . When they start complaining of injuries, then it's time for them to ease off."

Peter Barcia, chief of general surgery at Tripler, and who has a running family sees the self-esteem and confidence gained from running the marathon as important as the fitness which comes from training for it. "When the going gets tough later on in life, maybe the kids will have something in their back pocket to fall back on." All three doctor parents emphasize that children should not be forced to run and that they should not be pushed to win.

More Marathoners: "Jerome Tucker and wife Alice went all the way to Greece to run a marathon and Alice had to start the 26-mile race without Jerry, who got to the starting line late because he couldn't get out of the Greek lua—a language problem or something."—Don Chapman, *Advertiser* columnist.

Paul Condit's Repertoire . . .

Arty, a killer for hire, hadn't had a contract for a while and was getting rusty. Someone contacted him about a contract, but the price wasn't right. Being a man of principles, he said, "Well, if you can't meet my price, I'll do it for a dollar." He decided not to waste bullets so when he found the victim in the supermarket parking lot, he quickly and mercifully choked him to death . . . Just then, he heard a muffled gasp from a car nearby. An elderly lady was sitting in her car and had seen the whole incident. He walked over calmly and choked her quickly. By then, the parking attendant came running after sounding the alarm. So Arty had no choice but to choke him, too. By this time, police cars had surrounded the parking lot and officers converged on Arty with drawn revolvers so he gave up without a struggle . . . The evening news headlines read "Arty Chokes Three For A Dollar At Local Supermarket!"

Quotes . . .

Gastroenterologist **Gary Glober,** lecturing on acute pancreatitis: "One of my old profs used to say, 'The pancreas is a vicious and depraved organ.'"

Visiting hematology prof lecturing at a QMC Friday am medical conference explained a slide: "This is a peripheral blood smear of goose blood. We showed it to three different visiting profs . . . Notice how it is round with an elliptical nuclei . . . The first prof said, 'Let's repeat the differential . . .' The second asked, 'What's the family history like?' We said, 'Why, one just flew in yesterday.' Only the third prof guessed right: 'It's bird blood,' he said . . ."

Another slide showed a man with massive bilateral periorbital ecchymosis. "This is PPP (post proctoscopic purpura) in a myeloma patient who had a proctoscopic exam done without even doing a blood workup."

From The Mouths Of Babes . . .

(A career choice essay which inspired us . . .)

"Some may say I'm crazy. A medical career? Do you realize that you'll be spending your life forever learning? Yes, a medical career is a rigorous continuing process. It entails a willingness to make personal sacrifices and to pledge a total commitment to the welfare of others. If I were to choose one word to encompass this 'first aid' packet, it would be MOTIVATION—the driving force which provides the strength to strive, to achieve, and to expand. I can respect the person endowed with genius whose innate ability enables him to discern the complex world around him with such ease. I admire more the person who tries his very best, and whose endeavors reflect an unrelenting quest for knowledge and challenge. Both personally and academically, I am of this latter group. Things never come easy for me. I have to study harder than others and I have to put forth my very best effort. However, I do not let academics rule my life, though perhaps it is a top priority.

A wise man once stressed to me the importance of a well balanced being. "A healthy body produces a healthy mind," he said. He'd wake me at 6:00 in the morning and we'd head for the nearby park to jog. Exercise helped me conquer my fears and suppress my anxieties about growing up. From jogging, I took up tennis, canoe paddling and swimming.

Even when I left for college, his first question on our long distance phone calls would be "Have you been exercising?" He never emphasized academics. Perhaps he knew instinctively that I would be studying hard . . . I was never forced to study. I simply enjoyed the challenge and the competition.

Why medicine? It's the same challenge and competition. I cherish the idea of one day working with people, helping them find this same physical-mental balance in their lives. I am certain the fine correlation between physical and emotional fitness will have even greater meaning in medicine some day . . . I can think of no other field which offers this unique opportunity to help others by combining science and the personal touch.

To succeed, we must all pay our dues. What we expect from life can only be measured in our own efforts. Medicine seems to be the most challenging of the professional fields. And nothing inspires me more than the thought of dedicating one's life to its ideals."

Elected, Appointed & Honored

With 200 entries in seven categories for the 1980 AMA National Awards for Medical Speakers, Hawaii's own **Douglas Bell II** won first place for Testimony in March . . .

Honolulu's Sertoma Club presented **Wayne McKinney** with its Freedom Award in the health field. The Freedom Award is given to 14 Hawaii citizens annually for "contributing to make the State a better place to live."

Myron Shirasu was recently named QMC Chief of Staff and **William Sage** Chief of Staff-Elect . . . **James Steward,** Chief of Staff-*Emeritus* will serve as resource person and consultant . . .

Fish poisoning expert, **J.K. Sims** was appointed to head the Emergency Medical Services Systems Branch, State Health Dept. J.K. was training coordinator with the Hawaii Medical Association's EMS program . . .

Mona Bomgaars, faculty member of the John Burns School of Medicine since 1976 was appointed chief of the Communicable Disease Division of the State Health Dept . . . Mona succeeds **Anna Brault** who left to head the City Health Department . . .

Ariniwa Uematsu, Kaiser orthopod was named a fellow of the American Academy of Orthopedic Surgeons during its 48th meeting in Las Vegas, Nevada . . .

Miscellany

(Our nurse friend Louise Tokumura says:)

"What do you call a cow after it has had a hysterectomy?" "Decaffeinated . . ."

Dialogue from KMC Executive Committee Meeting

Ophthalmologist **Calvin Miura** reported that any new ophthalmologist has to do three majors with three observers to obtain surgical privileges . . . "We're getting so specialized that we only do cataracts . . ." Surgeon **Glenn Kokame** dourly observed: "O.S. or O.D.?"

Physicians Speak Up

Psychiatrist **Robert Marvit** defended the much criticized decision on the Randal Saito case: "I shall be the first to rise up against releasing a dangerous mentally ill offender if such an occasion occurs . . . However, I shall also be prepared to oppose having the mentally ill inappropriately imprisoned due to simplistic and archaic views . . . There is an old maxim that says, "Better nine guilty men go free than one innocent man be imprisoned."

Sports Medicine Symposium in Hilo on March 28 featured orthopod **Allen Richardson** speaking on "Athletic Injuries—Prevention and First Aid" and OB Gyn professor, **Ralph Hale** on "The Female Athlete/Reporting of Sports Injuries."

Psychiatrist **Sam Paltin** discussed "Anger and Disabilities" at the monthly meeting of the Easter Seal Stroke Discussion Group . . . Pulmonologist **Edward Morgan** gave a seminar on "Pulmonary Patient Education and Rehabilitation" at Wilcox Memorial Hospital on March 11 . . . Internist **John McDougall** who, with wife Mary, coauthored the diet book, "Making the Change," lectured on the treatment of obesity, hypoglycemia and diabetes at St. Francis Hospital in March . . .

Quintin Uy, KMC director of oncology services, says "A doctor's word is not final and patients shouldn't hesitate to question their physicians about an illness, medication or surgery . . . I'd like to educate patients to be consumers . . . I think a better informed patient is a better patient."

Lt. C. John Aoki, director of Family Practice Residency Program, Tripler wrote: Family physicians are trained over a rigorous three year curriculum to manage 90% of problems that present to a physician . . . They are also trained in the area of preventative medicine that emphasizes nutrition, exercise and other aspects of healthy living . . . They are unique in that they receive additional training in the important area of behaviorial sciences . . . This is the area that deals with the doctor-patient relationship and binds the art and science of medicine into an integrative whole."

John Betwee of Maui is for abolishing the insanity plea: "Abolish the insanity defense and the concept of men's rea (guilty mind) collapses followed by the rest of criminal law. That's OK too, because that structure is about to topple over from his own weight anyway."

George Goto, HMA Commissioner on Legislation and past president, commented on Edward Bybee's letter that "the abortion issue will remain an issue in Hawaii and will not die until this terrible law is eliminated from our land." George wrote: "Prior to the liberalization of the abortion laws, 40% to 50% of all maternal deaths resulted from illegal abortions. In addition, many more women became reproductive cripples . . . It would be a sad day when abortion must again be



performed illegally in unsanitary surroundings and by unskilled persons."

Nationally, the American College of Nurse-Midwives has accused the medical profession of resisting the practice of nurse-midwifery because of economic competition. There are two Oahu licensed and certified midwives and a third on Kauai. **Ralph Hale,** Chief of OB and Gyn at Kapiolani Children's Medical Center, says it's simply a matter of need . . . Nationally there is one OB man for every 12,000 people. In Honolulu, there is one for every 7,000. "I don't see a need for nurse-midwives in downtown Honolulu where there are an adequate number of physicians. The nurse-midwife service is perfect for rural areas where they can serve as physician extenders."

Fred Burkle, adolescent medicine, spoke on "Understanding Normal Adolescent Emotional Development: Separation, Individuation, and the Need to Rebel" at Punahou School on March 3. **Russell Hicks** and **Sharon Bintliff** were on the panel, "Sex and Drugs and Rock 'n' Roll—Is Everybody Really Doing It?" on March 17.

On February 14, **Willis Butler** wrote: "Your editorial on El Salvador (2/7) while perhaps well intentioned, is naive, ill informed and timid . . . The Revolutionary Front in that country is broad based, and its leaders are realistic and far sighted as well as courageous. If the U.S. government can give up simplistic fixes and its paranoia about revolution, it might see the emergence in poor nations of progressive regimes that some corporations could work with, at least in foreseeable future . . . But for that to happen in El Salvador, all U.S. assistance to a government of thugs and the super rich, bitterly hated by the mass of people, must cease immediately. The alternative is a larger, longer and more terrible Vietnam war . . ."

Fronk oncologist **Jack Keenan** credits the "hippies" for the development of a special Chemotherapy Cap designed to reduce hair loss in patients undergoing chemotherapy . . . Jack explains that the headbands worn by those young people even when being treated with chemotherapy prevented hair loss by restricting the amount of drugs reaching the hair roots. Further experimentation indicated that the use of icepacks had the same effect. As Jack puts it: "Hair is important to any person . . . the traditional crowning glory . . ."

A $5.2 million ultra-modern wing was completed at Kauai Veterans Memorial Hospital two years ago, but for most of the time the wing has been closed until last month when the ER was opened. Still closed are the ICU and CCU which Sen Dante Carpenter calls "one of the most sophisticated this side of the Rocky Mountains." The problem is lack of nurses. There is a critical shortage of qualified nurses both statewide and nationwide and also the housing shortage in the Waimea area. Still another problem is that the State offers new nurses pay at several hundred dollars below elsewhere . . . Meanwhile, the hospital will continue its practice of stabilizing patients, then shipping them by ambulance to Wilcox Hospital in Lihue . . . (Somebody, somewhere apparently goofed . . .)

The March issue of Cosmopolitan carries excerpts from **Norman Goldstein's** book, "The Skin You Live In." (According to don chapman . . .)

Neurosurgeon **Maxwell Urata** was awarded a special HCMS journalism award at an HICC annual meeting for the following editorial comment which appeared in the Sept. 24 Star Bulletin: "In view of your recent editorial about the medical school, **Dean Rogers'** reply and our current acute nursing shortage, I would like to make a few observations . . . Most medical schools were established to improve a physician shortage in that particular area. Hawaii's medical school was established for reasons that are still obscure to me, other than it was a state policy of the late Gov. John Burns. It seems to me that Gov. Burns made two major errors in the field of higher education in Hawaii: the School of Medicine and the School of Law. Neither of these schools fits the usual reason for establishment: We do not have a physician nor an attorney shortage . . . However, the real purpose of this letter is to propose an alternative to our current problem: a nursing shortage and a doctor glut. I would suggest that the medical school be cut back to a two-year program or be eliminated entirely and such funds freed up to be used to improve the School of Nursing and in general improve the graduate education curricula at the University . . . The School of Nursing has not served this community well. It trains an elite group that finds it difficult to adapt to the rigors of bedside nursing, which is the pressing need in this community. When these nurses graduate, they are no more equipped to handle the assignment of patient care in the hospital than had they not gone to nursing school . . . Why then give the school more money? Give it the money to expand and diversify. Allow some of the students who are not interested in a baccalaureate degree to attend two or three year programs (as they did in the past) and train good bedside nurses once again. This training would emphasize practical experience at the bedside, not theory.

The hospital administrations have a share of the blame in this current nursing shortage as well. Like the School of Nursing, they have relied on the allure of the islands to bring in qualified nurses, especially from Canada, to fill the gap at a pay scale far below that found on the Mainland. The allure is apparently no longer there, especially when coupled with the poor pay scale. It is clear that this state must train its own nurses and pay them well . . ."

Telephone Messages . . . Misconstrued . . .

"Dr. Y . . . Dr. Urata called that Mr. S.S. slipped down. He will do surgery this coming Saturday" (Explanation: Dr. Urata called to say that Mr. S.S.'s condition (communicating hydrocephalus post op) was deteriorating. And that he was going to revise the shunt.)

"Dr. Y . . . Dr. Luning called. He said to make starting time for next week. Wants you to call him back . . ." (Explanation: Dr. Luning had actually said "call Mid Pac" which sounded like "call me back.")

◇

Our "Angels"

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"Happy Birthday."

Hawaii Academy of Family Physicians' Newsletter

DON AND MARLIES FARRELL

No **new members** to report this month. However, **Ernest Bade** and **Rod Miller** were reelected to three-year Active memberships, having completed at least 150 hours of CME credit within the past three years. Congratulations!

Mahalo to **Pat and Carolyn Walsh** for hosting our last dinner meeting. **Mead Johnson** provided the liquid refreshments this time and **Carolyn** made some delicious pupus to precede the catered dinner. **John McDonnell,** a Tripler allergist, spoke on "Newer Concepts in Asthma Treatment," and **Pat Walsh** made everyone think about safety with his presentation on car restraints for infants and toddlers. **Alfred Burden** and **Arch Wigle,** along with their spouses, came from outer islands; they had attended the HMA meeting a day earlier, at which the unit rule was soundly defeated. The next dinner meeting will be held in early July, watch your mail. We do hope you read it!

We say Aloha to two members of our Executive Council this month!! **Bob Todd,** President-elect, is being transferred by the Army much sooner than expected. He goes to the Health Services Command at Fort Sam in Houston, Texas where he becomes Chief of Ambulatory Care, responsible for FPs, GPs, nurse clinicians and operational control of 187 clinics and hospitals in the continental US, Alaska, Hawaii, Panama and Puerto Rico. A big job, we wish **Bob** well!! **Harold Timboe** completes his Tripler residency and his new assignment is also a plum: He becomes Division Surgeon for the 82nd Airborne Division, a 16,000 member combat unit. **Harold** will be responsible for healthcare delivery, policy and planning, and supervise 20 physicians, 15 PA's and 600 medics. Congratulations to both **Bob** and **Harold**, we will miss both. **Bob** was also our Education Committee Chairman. **James Tsuji,** president, has appointed **John Aoki** to assume this responsibility.

The co-editors of this **News-Letter** attended the AAFP State Officers Conference and Administrative Workshop in Kansas City in April. It was a well thought-out and executed session with many opportunities to exchange ideas with counterparts from other states as well as Headquarters staff. Some of the highlights from the Admin.Workshop: A day-long seminar on "Management of the Volunteer Association"; a Chapter Executive session that included discussion of common problems such as CME records and membership services; and a speech by **Richard Bolling, (D-Mo),** a legislator since 1948 and presently the powerful chairman of the House Rules Committee. He foresees nothing but economic disaster if **Reagan's** policies are implemented. May he be proven wrong! The SOC featured an address by president **Sam Nixon** and reports from the various chairmen of Committees and Commissions. Officers and members of the Board of Directors made themselves available for a question-and-answer session; and **Edward Brand,** Assistant Secretary for Health, U.S. Dept. of Health and Human Services and also an Academy member, briefed the audience on latest developments in Washington, such as the large cutbacks in funding for all areas of healthcare expected. A thoroughly enjoyable experience was a debate between Reid Buckley, (the third Buckley brother), and Nicholas Johnson, a consumer advocate, on: "Big Daddy Government—Ripoff or a Good Thing." The 1981 Annual Meeting in Las Vegas was previewed in a program of musical skits with various national officers displaying their singing and acting talents. Hilarious!—The conference closed with an Open-House-Luncheon at Headquarters, where we even got to "kick" the computer that seems to give us problems at times. We found the staff more than eager to listen to our concerns and anxious to help solve any problems we might have. Conference participants commented more than once that there is hardly another national association of this size, more than 50,000 members, which is as accessible to its members and constituent chapters as AAFP. We heartily agree!

Aloha,

Don and Marlies Farrell

Book Reviews

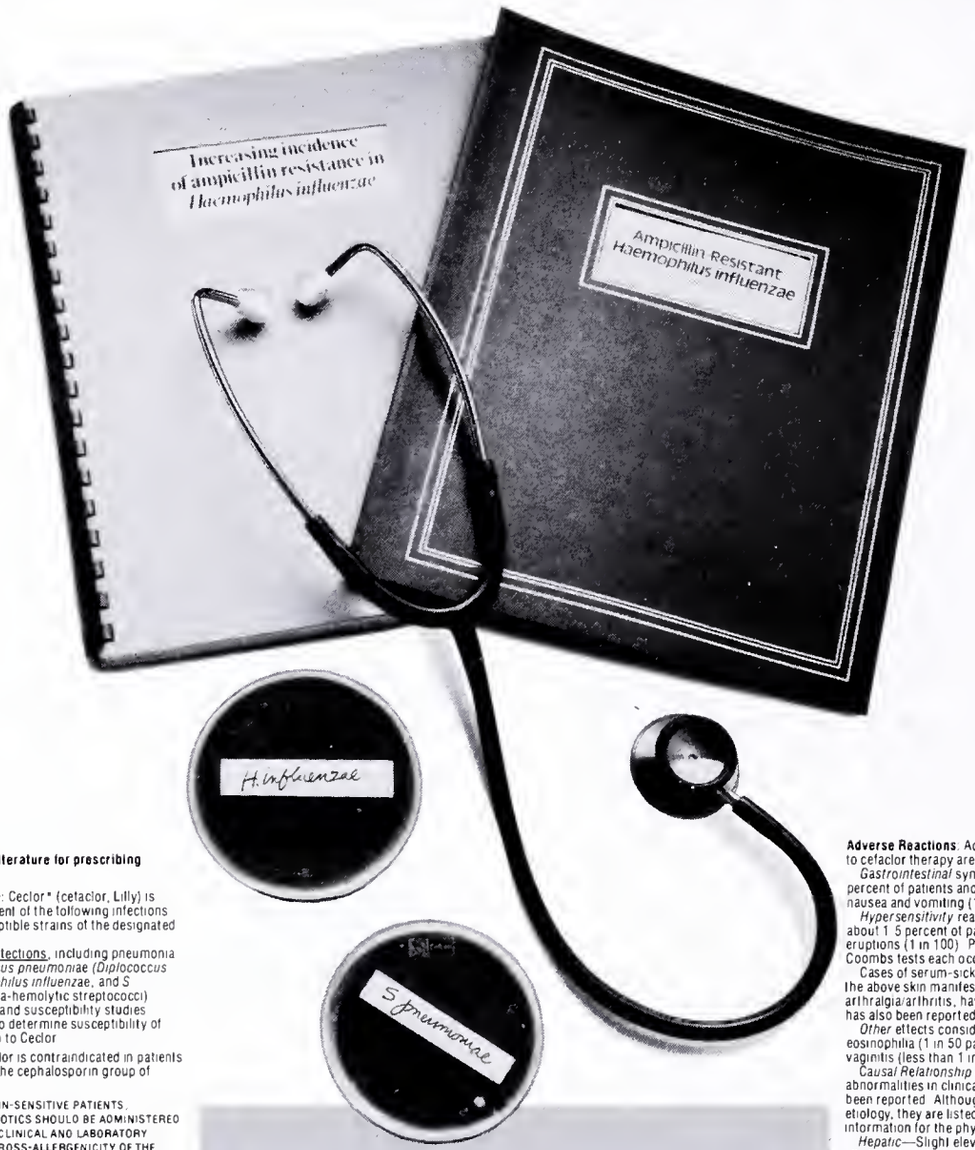


Microbial Diseases, *Notes, Reports, Summaries, Trends, compiled and edited by Carl W. May, 1980 edition.*

This 322-page volume consists solely of material reproduced directly from the weekly publication of the U.S. Public Health Service's Center for Disease Control, *Morbidity and Mortality Weekly Report.* The publisher recommends this book as a supplement to older texts or an ancillary text for students. Students who have done their preliminary reading may find this book of limited interest. Physicians are unlikely to benefit from it; the material is of limited interest to those other than infectious disease specialists, and the latter group will already be familiar with its contents.

RICHARD I. FRANKEL, M.D.

An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-5]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor

Pulvules®, 250 and 500 mg

Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Ceclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae*, and *S pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE)

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest* tablets but not with Tes-Tape* (Glucose Enzymatic Test Strip; USP, Lilly)

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90)

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients

Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported. Anaphylaxis has also been reported

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [103080R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S pneumoniae* or *H influenzae*.

Note: Ceclor* (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

Lilly

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Carolina, Puerto Rico 00630

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Feelings vs.

Some people feel that I am misused and overused and that I'm prescribed too often and for too many kinds of problems.

The FACT is that approximately eight million people, or about 5 percent of the U.S. adult population, will use me during the current year. By contrast, the national health examination survey (1971-1975) found that 25 percent of the U.S. adult population experiences moderate to severe psychological distress. Additionally, studies of patient attitudes revealed that most patients have realistic views regarding the limitations of tranquilizers and a strong conservatism about their use, as evidenced by a general tendency to *de*crease intake over time. Finally, a six-year, large-scale, carefully conducted national survey showed that the great majority of physicians appropriately prescribe tranquilizers.

Some people feel that patients being treated with anxiolytic drugs are "weak," can't tolerate the anxieties of normal daily living, and should be able to resolve their problems on their own without the help of medication.

The FACT is that while most people can withstand normal, everyday anxieties, some people experience excessive and persistent levels of anxiety due to personal or clinical problems. An extensive national survey concluded that Americans who do use tranquilizers have substantial

Facts

justification as evidenced by their high levels of anxiety. It was further noted that antianxiety drugs are not usually prescribed for trivial, transient emotional problems.

Some people feel afraid of me because of the stories they've heard about my being harmful and having the potential to produce physical dependence.

The FACT is that there are thousands of references in the medical literature documenting my efficacy and safety. Extensive and painstakingly thorough studies of toxicological data conclude that I am one of the safest types of psychotropic drugs available. Moreover, I do not cause physical dependence if the recommended dosage and therapeutic regimen are followed under careful physician supervision. However, I can produce dependence if patients do not follow their physicians' directions and take me for prolonged periods, at dosages that exceed the therapeutic range. Patients for whom I have been prescribed should be cautious about their use of alcohol because an additive effect may result.

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The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies The physician should periodically reassess the usefulness of the drug for the individual patient
Contreindiceted: Known hypersensitivity to the drug Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy
Werninge: Not of value in psychotic patients Caution against hazardous occupations requiring complete mental alertness When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures Advise against simultaneous ingestion of alcohol and other CNS depressants Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months After extended therapy, gradually taper dosage Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence

***Usege in Pregnency:* Uee of minor trenquilizers during first trimester should elmost elweys be evolded beceuee of increesed risk of congenitel melformetions es suggested in severel studies. Consider possibility of pregnency when instituting therepy; edvise petients to discuss therepy if they intend to or do become pregnent.**

Preceutions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies Observe usual precautions in impaired renal or hepatic function Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation
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Doeege: Individualize for maximum beneficial effect *Adults* Anxiety disorders, symptoms of anxiety, 2 to 10 mg o i d to q i d , alcoholism, 10 mg t i d or q i.d in first 24 hours, then 5 mg t i d or q i.d as needed. adjunctively in skeletal muscle spasm, 2 to 10 mg t i d or q i d , adjunctively in convulsive disorders, 2 to 10 mg b i d to q i d *Geriatric or debilitated patients* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated (See Precautions) *Children* 1 to 2½ mg t i.d or q i d initially, increasing as needed and tolerated (not for use under 6 months)
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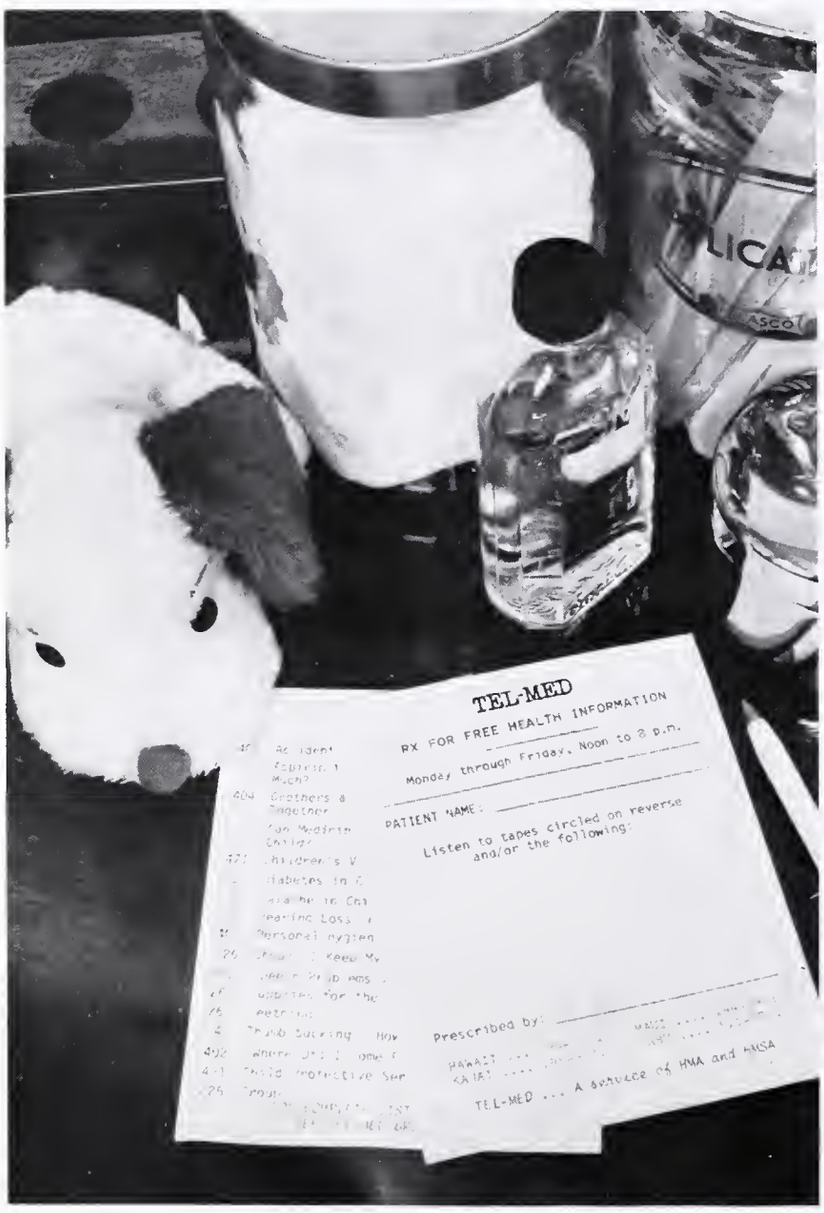
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A Comparison of Inborn versus Transferred Neonates Admitted to a Special Care Unit

DAVID EASA, M.D., KENNETH ASH, M.D., RODNEY B. BOYCHUK, M.D., MICHAEL J. LIGHT, M.B., M.R.C.P. (U.K.), *and* MARK LaBARRE, *Honolulu*

• *This retrospective study of 343 infants admitted to a Special Care Nursery in a regional perinatal center over a 1-year period compares the mortality and morbidity of those infants born within the center with those transferred from outside hospitals. Few significant differences were found. These included a shorter duration of oxygen therapy and fewer complications in inborn infants between 1,000 to 1,499 gms. with respiratory distress syndrome, as well as lower mortality in the overall inborn group of infants of 1,500 to 1,999 gms. It is suggested that the early referral of high risk infants to the regional perinatal center from outside hospitals minimizes differences in mortality and morbidity.*

Neonatal mortality for the State of Hawaii has declined over the last 12 years (Table 1), paralleling a similar trend throughout the United States[1-6] and England.[7-9] Factors contributing to this decline include improvement in antenatal care,[4] advances in neonatal care, technological innovations in monitoring equipment, and the development of regional perinatal centers.[1-6,9,10] Perinatal centers have had a profound effect, not only by centralizing the care of the highest risk mothers and infants into one center and coordinating the maternal and infant transport systems, but also by developing educational programs for referring hospitals throughout the region.

Infants admitted to regional perinatal centers include inborn infants and those transferred from outlying hospitals. We questioned whether high risk infants born within the center had less mortality and morbidity.

Materials and Methods

At Kapiolani-Children's Medical Center, serving as the perinatal center for Hawaii and the Pacific Basin, are delivered 6,000 infants annually. Although 60% of the infants admitted to the Special Care Nursery (SCN) originate from the inborn high risk population, the remaining 40% of SCN admissions are infants transferred postnatally from referring hospitals throughout the state. Patient charts were reviewed of infants admitted to the Special Care Nursery between September, 1978, through September, 1979. The total number of infants during this period was 343, of which 143 were transferred infants. These infants were grouped into 12 diagnostic categories, found in Table 2.

Of the transferred infants, 48 percent were transferred from hospitals on Oahu, 50 percent from neighbor island hospitals, and 2 percent from the Pacific Basin. Statistical studies in this paper utilize chi-square analysis and analysis of variance. Data from non-surviving infants was excluded from calculations involving duration of hospitalization, duration of oxygen and ventilator therapy, and rate of complications.

Results

An analysis of mortality by birth weight categories is seen in Table 3. The overall survival

TABLE 1.—*Total Number of Live Births, Premature Births and Neonatal Deaths for State of Hawaii, by Resident Population and Year*[1]

YEAR	TOTAL	PREMATURE BIRTHS[3]		NEONATAL DEATHS[4]	
	LIVE BIRTHS[2]	NUMBER	PERCENT	NUMBER	RATE
1966	14,920	1,205	8.2	235	15.8
1967	14,735	1,174	8.1	198	13.4
1968	14,470	1,202	8.4	211	14.6
1969	15,550	1,237	8.0	239	15.4
1970	16,361	1,243	7.7	252	15.4
1971	15,780	1,217	7.8	194	12.2
1972	15,364	1,089	7.2	213	13.8
1973	15,328	1,057	7.0	170	11.1
1974	15,472	1,079	7.1	176	11.4
1975	15,689	1,001	6.5	148	9.4
1976	16,414	1,067	6.5	126	7.7
1977	16,983	1,070	6.3	134	7.9
1978	16,431	1,027	6.3	125	7.6

[1]Department of Health, Statistical Report, individual reports 1966 through 1978.
[2]Number of live births in resident population.
[3]Total number of single births under 2501 grms., percent of single births for year.
[4]Infant deaths under 28 days of age, rate=total# ÷ total# of live births × 1000.

Accepted for publication, August, 1980.

TABLE 2.—*Admission Diagnoses of Study Group Infants*

DIAGNOSIS	INBORN NUMBER OF PATIENTS (%)		TRANSFERS NUMBER OF PATIENTS (%)	
Transient Tachypnea—Mild Respiratory Distress Syndrome	42	(21%)	18	(13%)
Respiratory Distress Syndrome—Moderate and Severe	49	(25%)	49	(34%)
Meconium Aspiration Syndrome	10	(5%)	11	(8%)
Pneumonia	4	(2%)	3	(2%)
Perinatal Asphyxia	11	(6%)	5	(3%)
Prematurity with Apnea and Bradycardia	15	(8%)	4	(3%)
Other Pulmonary Problems	9	(5%)	1	(1%)
Hyperbilirubimemia	27	(13%)	12	(8%)
Sepsis	6	(3%)	4	(3%)
Birth Defects	8	(4%)	14	(10%)
Surgical Conditions	6	(3%)	15	(10%)
Other	13	(6%)	7	(5%)
Total	200	(100%)	143	(100%)

rate of both inborn and transferred infants was identical: 88%. It is noted that the under 1,000 gm. infants in both inborn and transferred groups had impressive survival rates of 64% and 60% respectively. Significant differences in survival were noted only in the 1,500 to 1,999 gm. category ($p < 0.02$). All of the inborn infants survived, compared to 89% of the transferred infants.

Three categories of infants with respiratory disease were studied in more detail (Table 4). The first group had either transient tachypnea of the newborn or mild respiratory distress syndrome, and did not require endotracheal intubation or assisted ventilation. This group of 42 inborn and 18 transferred infants was characterized by little morbidity and mortality. The longer hospital stay of the inborn group represented the predominance of smaller infants of lower gestational age, not differences in morbidity.

The second group of infants studied had moderate or severe respiratory distress syndrome. All 49 inborn and 49 transferred infants in this category required endotracheal intubation and assisted ventilation. When analysis was made after separating the group into 4 weight categories (Table 5), certain differences between the inborn and transferred groups were observed. The group of infants less than 1,000 gm. with respiratory distress syndrome had a high mortality rate. Of the 6 infants in this category, the one survivor was an inborn infant. Inborn infants in the 1,000-1,499 gm. group, compared with transferred infants, required less time in oxygen and developed fewer complications. These differences were statistically significant.

Meconium aspiration syndrome comprised

TABLE 3.—*Overall Survival Statistics*

BIRTHWEIGHT GROUP	INBORN		TRANSFERS	
	NUMBER	SURVIVORS (%)	NUMBER	SURVIVORS (%)
<1000 grams	11	7 (64%)	5	3 (60%)
1000-1499 grams	41	33 (80%)	13	12 (92%)
1500-1999 grams	45	45 (100%)*	35	31 (89%)*
>2000 grams	103	91 (88%)	90	80 (89%)
TOTAL	200	176 (88%)	143	126 (88%)

*$p < .02$

TABLE 4.—*Comparison of Patients with Pulmonary Disease*†

	TTN* AND MILD RDS*		MODERATE/SEVERE RDS		MECONIUM ASPIRATION SYNDROME	
	INBORN	TRANSFERS	INBORN	TRANSFERS	INBORN	TRANSFERS
Patients	42	18	49	49	10	11
Survivors/(%)	41 (98%)	18 (100%)	38 (78%)	41 (84%)	8 (80%)	10 (91%)
Hospitalization (Average Days)**	21.1	12.3	36.3	27.2	7.6	12.6
Assisted Ventilation (Average Days)**	—	—	5.0	4.5	0.3	1.9
Oxygen (Average Days)**	1.2	1.2	9.4	8.3	1.3	2.9

† Data in this table not statistically significant.
* TTN = Transient Tachypnea of the newborn; RDS = Respiratory Distress Syndrome.
**Survivors only.

the third group of 10 inborn and 11 transferred infants. From Table 4 and Table 6, it appeared that on the average, the inborn group had a shorter hospitalization, required fewer days of mechanical ventilation and oxygen therapy, and developed fewer complications than that of the transferred group. However, none of these differences were statistically significant.

TABLE 5.—*Diagnostic Category: Moderate or Severe RDS*

BIRTHWEIGHT	<1000 GMS.		1000-1499 GMS.		1500-1999 GMS.		>2000 GMS.	
	INBORN	TRANSFERS	INBORN	TRANSFERS	INBORN	TRANSFERS	INBORN	TRANSFERS
Patients	4	2	18	5	11	20	16	22
Survivors/(%)	1 (25%)	0 (0%)	12 (67%)	4 (80%)	11 (100%)	18 (90%)	14 (88%)	19 (86%)
Hospitalization* (Average Days)	172	—	48	62	33.8	31.8	18.6	15.6
Assisted Ventilation* (Average Days)	14	—	5.4	12.8	5.0	4.4	4.1	2.9
Oxygen (Average Days)*	26	—	9.0**	29**	10.0	7.3	8.1	5.1
Patients with Complications†/(%)*	1 (100%)	—	5 (42%)††	4 (100%)**	7 (64%)	7 (39%)	3 (21%)	8 (42%)
Complications† Per Patient (Average)*	4	—	0.58††	2.25††	1.0	0.7	0.29	0.53

* Survivors only
† Complications include pulmonary air leaks, patent ductus arteriosus, bronchopulmonary dysplasia, retrolental fibroplasia, others.
**p<.01
††p<.05

Discussion

Ideally, modern perinatal care requires the delivery of high risk mothers at a regional perinatal center. There the fetus can be monitored with ultrasonography, serial estriol measurements, oxytocin challenge test, amniotic fluid analysis, fetal heart rate monitoring and fetal scalp blood pH in order to evaluate fetal well being and determine the optimal time of delivery. At delivery, a team of specialists in neonatal care is available to provide resuscitation, utilizing well-maintained equipment.

TABLE 6.—*Complications Associated with Meconium Aspiration Syndrome Diagnosis Group*†

	INBORN	TRANSFERS
Patients*	8	10
Patients with Complications/(%)*	2 (25%)	4 (40%)
Complications per patient (average)*	0.25	0.7
Types of complications:*		
Pulmonary Air Leak	1	0
Persistent Fetal Circulation	0	4
Renal Failure	0	2
Others**	1	1

†Data in this table not statistically significant.
*Survivors only.
**Coagulopathy, sepsis, lobar atelectasis.

In the past we have assumed, in accordance with the findings of others,[3,5,6,9] that high risk infants born within the perinatal center have a better outlook than those transferred from outside hospitals. Other centers within the regional network have less equipment and fewer personnel, and delays in mobilizing transport services may complicate them to more complications and increased mortality. However, aside from the few exceptions noted, the data from this study does not substantiate this assumption.

The validity of these findings is based on the presumption that the study groups are comparable. This may not be the case. Neonates born within the perinatal center included those at highest risk, as well as some born for anticipated, but unrealized, high-risk problems. The group of transferred infants included a heterogenous population referred at the discretion of numerous physicians. Also, the sickest and smallest infants may have died before transfer could be accomplished. Other studies attempting to measure the impact of the regional perinatal center on neonatal morbidity and mortality[1-6,9,11] have met with similar difficulties in interpreting their data.[1,3,4,5]

Finally, assuming validity in the design of this study, one possible explanation for these findings is that sick infants born in hospitals outside this perinatal center were usually referred at or near birth for transfer. Unfortunate delays in mobilizing personnel (neonatal fellow and SCN nurse) and ground and air ambulance services and the large distances between hospitals in this unique island state were responsible for most of the delays (average = 4 hours).

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Several modes of transmission help giardia get along . . .

Clinical Giardiasis on Maui

LARRY L. KILLION, M.S.P.H.*, ROBERT S. DESOWITZ, Ph.D., D.Sc.**, *and* NED H. WIEBENGA, M.D., M.P.H.†

• *Giardiasis is the major cause of parasitic diarrheal illness in the U.S. A follow-up study on 50 clinical giardiasis patients on the island of Maui showed Caucasian children between one and nine years were most likely to manifest symptoms of giardiasis.*

The flagellate *Giardia lamblia* is an intestinal protozoan. Trophozoites, the active forms, are found in the upper small intestine. The ventral surface of the organism, modified to form a "sucking disk," adheres to the intestinal lumen. Cysts are typically found in the stool of an infected individual. Infective cysts, with four nuclei, are easily differentiated from other protozoan cysts.

The presence of cysts or trophozoites in the stool indicates infection with *Giardia*. Infection, however, does not necessarily mean disease. Estimates of the percentage of a given population harboring *Giardia* range from 1% to 30%, with those showing clinical illness from 20%[1] to 50%[5]. One of the problems with asymptomatic carriers is that long-term follow-ups to insure that they remain asymptomatic have often been neglected. The most recent estimate is that 7% of the American adult population are carriers[4].

TABLE 1.—*Parasitiological Findings of Stools Submitted by Physicians to the State Department of Health Laboratory on Maui (6/30/72-12/31/78).*

YEAR	TOTAL # OF STOOLS SUBMITTED TO LAB*	% POSITIVE FOR OVA AND PARASITES	% OF TOTAL # OF STOOLS WITH GIARDIA**
1972	325 (from 6/30)	4.0	1.2
1973	303	4.6	0.0
1974	322	6.8	0.6
1975	441	11.6	0.9
1976	389	13.6	1.3
1977	771	15.7	4.1
1978	786	12.0	5.7

**Adjusted values, all watershed samples excluded.*
***Repeat samples excluded.*

Giardia is known to infect a wide variety of animals other than man. *Giardia* species have been isolated from monkeys, rodents, dogs, cats, and frogs. Levine described 11 species in 1973[2]. Zoönotic transmission has been shown from man to dogs. *Giardia lamblia* (human giardia) was found to infect beagle puppies[3]. However, animal-to-man transmission has yet to be shown.

Infection occurs by ingestion of viable cysts. A susceptible individual must somehow come in contact with an infected person's feces. The most frequent modes by which cyst ingestion occurs are drinking fecally contaminated water, hand-to-mouth transfer of cysts via contaminated soil, or person-to-person contact.

The incubation period is 6 to 22 days. Acute symptoms frequently begin with explosive, watery, foul diarrhea accompanied by gas and abdominal midepigastric cramps. The infection may develop into a subacute or chronic state. In some cases, the acute stage may be prolonged for several months, leading to a malabsorption syndrome. Not all infected persons will manifest these symptoms. It is the covert or inapparent carrier who is of the greatest concern in the spread of the disease. Currently, three drugs are available for treatment: Flagyl (metronidazole); Atabrine (quinicrine hydrochloride); and Furazolidone, the only drug available as a suspension.

TABLE 2.—*Percent Positive of Stool Samples Submitted to the State Department of Health Laboratory on Maui (6/30/72-12/31/78)***

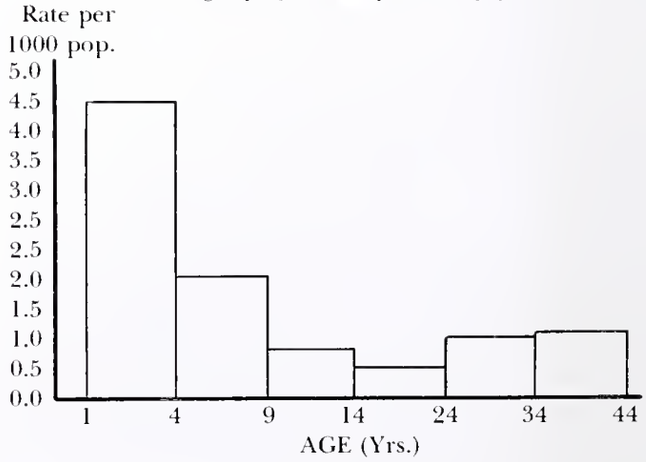
YEAR	TRICHURIS	HOOKWORM	ASCARIS
1972	0.3	0.6	0.0
1973	2.3	1.3	0.3
1974	3.4	2.7	0.3
1975	7.4	1.4	4.5
1976	2.6	5.7	3.0
1977	5.1	5.7	0.6
1978	3.7	2.7	0.2

**Watershed samples excluded*
***Repeat samples included*

Due to the increased rate of clinical enteric parasitic infections over the last few years on Maui (Table 1), it was believed that a pilot study was needed to better define any problems, and to narrow the target population into high risk groups.

This paper is the result of case follow-ups,

FIGURE 1.—*Age Specific Rates per 1000 population.*



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Accepted for publication January, 1981.

and reports the basic descriptive epidemiological patterns of giardiasis as it occurred in 50 clinically ill patients on the island of Maui.

Materials and Methods

Data were collected from June 30, 1972, through August 15, 1978. A "case" was defined as a State laboratory-diagnosed *Giardia*-positive person who was clinically ill during the study period. Laboratory records revealed 59 *Giardia*-positive cases. Nine of these were lost to follow-up and were dropped from the study population. Permission for case contact was obtained through the respective physicians. Initial case contact was made by telephone. Patients who were reluctant to release information over the telephone were mailed a questionnaire, or personally interviewed. All questionnaires sent out were returned. Data collected for each case included age, sex, ethnicity, and geographical location at the time of illness. Age was recorded to the last completed year. Ethnicity was self-identified. The denominators used for population rates were taken from the population characteristics of the island of Maui, Office of Economic Opportunity Update for 1975. Although it may be argued that these denominators may not be appropriate and that the true numbers may be slightly inflated, the proportions remain the same.

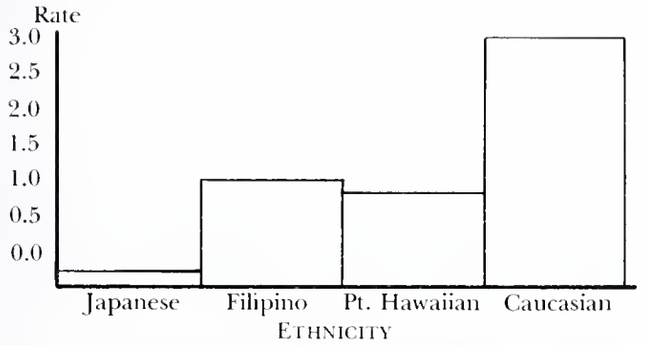


FIGURE 2.—*Bargraph of Ethnic Specific Rates per 1000 population.*

Results

It can be seen that there is not only a significant increase of *Giardia* cases by year, but there is an overall increase of enteric parasitic infections, $p < .0005$ for the 2 tailed test, in general (Table 1). The difference between the relative proportions of *Giardia* cases by year is statistically significant at the $p < .0005$ level for the 2 tailed test. A comparative breakdown of other enteric parasites by year can be seen in Table 2.

Sex was not demonstrated to be a factor in the distribution of the disease. Of the 50 in the study population, 23 were male and 27 were female. Age, however, was shown to be an influencing variable (Figure 1). This data suggests a tendency for children between the ages of 1-9 years to manifest the symptoms of giardiasis, $p < .0005$ for the 2 tailed test. The age adjusted rate is 1.5 per 1000 population.

Because of the diversity of the ethnic population on the Island, ethnicity was suspected as a variable. Figure 2 shows the ethnic specific rates per 1000 population. It can be seen that Caucasians are most likely to become ill with giardiasis, $p < .001$ for the 2 tailed test. There was some clustering of cases in the Haiku and Lahaina areas. A common source, however, could not be determined.

To address the question of ethnic population variance among the various districts of Maui, ethnic/district–specific rates were highest among Caucasians in the Lahaina, Kihei, and Kula areas, $.001 < p < .01$.

There was no association between fecal contamination levels of water supplies and clustering of cases.

Discussion

Evidence was found that age, as well as ethnicity, may be intrinsic factors in the distribution of the disease. As to age, personal hygienic habits may predispose children to infection and subsequent disease. Children are also more likely to come in contact with fecally contaminated soil. This could imply an animal-to-man transmission, which has not yet been demonstrated.

As to ethnicity, the higher prevalence rate of giardiasis among Caucasians may be due to a tendency for Caucasians to seek medical assistance for an episode of diarrheal illness. Socioeconomic status may also be an influencing factor. These are strictly assumptions, but should be considered when casual factors are sought in the distribution of the disease.

Stools were collected from pet dogs of some of the patients. This was not included in the study design. However, 2 of 9 dogs sampled were *Giardia* positive.

The sudden increase in the number of stool samples submitted from 1976-1978 may have been due to an increased interest in the medical community. Whether this is a result of the efforts of this study or an influx of new physicians, most doctors on Maui are now considering giardiasis in their differential diagnosis of diarrheal illness.

There is increasing clinical and epidemiologic evidence that *Giardia lamblia* is, indeed, a prevalent pathogen of man. It is hoped that this study will contribute to a better understanding of the significance of *Giardia* in Hawaii.

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Football Injuries in Hawaii 1979

RALPH W. HALE, M.D. *and* WAYNETTE MITCHELL*

• *Football injuries have become a great concern to parents, coaches, schools and legislators over the past twenty years. In 1963, Dr. Tabrah[6] presented a review that revealed that high school was 13,666 times more dangerous than underground coal mining. His report on Big Island schools showed that, in 1962, injuries resulted in 111 days of lost time.*

In 1974, a bill was introduced into Congress to require trainers to be present at all high school and college athletic events. Although this bill was defeated, Congress mandated a study be undertaken to determine the extent and number of injuries. This report reviewed 1,510 schools and 980 colleges and was completed during the 1975-76 year.[1] Over 1,000,000 injuries occurred in sports during that year, and 111,000 were classified as major. In this study, football was found to have an injury rate of 242 per 1000.

Other studies were also taking place about the same time, including the NCAA study on Fatalities.[3] In 1975, 15 players died of football injuries and, in 1976, 18 players were killed. As a result, the rules committee adopted more stringent rules, especially designed to protect the players from neck injuries. Head and neck injuries were the leading causes of death. These rule changes appeared to have had some effect as the fatalities dropped to 10 in 1977 and 9 in 1978.

TABLE 1.—*Injuries by Conference*

	VARSITY	FR/JV
OIA	141	5
ILH	432	112
Neighbor Island	50	3

As a result of the interest generated, a number of states began to survey their incidence of injuries. Some even developed controlled studies to evaluate conditioning as a preventive measure.[4]

The John A. Burns School of Medicine Committee on Sports Medicine also became interested at this time and determined to look at the incidence of injuries in Hawaii. The Honolulu Advertiser agreed to participate and help fund this study, which was undertaken during the 1979 athletic year.

Materials and Methods

It was initially determined that the method which had been the most successful nationwide was the use of a questionnaire. Samples were obtained from the National High School Athletic Federation, State of Oregon and State of Oklahoma, then modified to suit Hawaii.

Each public and private school, maintaining a varsity athletic program, was contacted after approval by the Board of Education. The head coach or other school official was interviewed and the study explained. Copies of the questionnaire were then supplied, with the request that they be returned to the medical school.

TABLE 2.—*Activity at Time of Injury*

Blocking	27%
Tackling	20%
Blocked	14%
Tackled	12%
Running—No Contact	11%
Pile-Up	7%
Other Activity	9%

The data was then stored until the end of the football season to allay some coaches' fears that inadvertent leaks of injuries could have a deleterious effect upon their program. All participant coaches have been sent a copy of the information.

There was no mechanism available to guarantee 100% participation by the schools or to assure that all injuries were reported. In many instances the questionnaire was only partially completed therefore, the interpretation of this information is limited.

TABLE 3.—*Type of Surface*

	ARTIFICIAL	NATURAL
Blocking	47	141
Tackling	41	99
Blocked	27	73
Tackled	31	55
Running—No Contact	11	67
Pile-Up	9	36

Results

There were 885 injuries reported for the 1979 football season. The 24 schools responding included 14 OIA schools, 4 ILH schools and 6 neighbor island schools. Of the total number of injuries, 623 occurred in varsity athletes and 118 occurred in freshman or junior varsity teams. Table I shows the breakdown by conference. The discrepancy between the teams appears to be due to the more accurate reporting maintained by the ILH schools. Further investigation reveals that these ILH schools are the only ones having athletic trainers present for practices and games. All

*Funding and assistance for this project was given by the Honolulu Advertiser.

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of the other schools relied upon coaches or volunteers to recognize the injuries and report them.

Injuries were evaluated by month of the season, type of the activity and time of the injury. The largest number of injuries occurred in preseason (45.3%), while 27.5% occurred in the first month of play. Injuries occurred fairly equally

Table 4.

	GAME QUARTER	HOUR OF PRACTICE
First	20%	30%
Second	28%	53%
Third	22%	5%
Fourth	20%	12%

for the first 4 weeks of play; for the next 6 weeks, the types of injuries were the same, but 40% fewer than in the first 4 weeks. In the last weeks, the numbers of injuries were fewer than 20% of those of the first 4 weeks. The injuries were about equally divided between practice and game. Most of the injuries (76%) occurred during a running play, while 16% occurred during a pass play and 5% on the kick off. Table 2 lists the activity at the time of injury.

These injuries were further evaluated as to whether they occurred on artificial turf or grass.

Table 5.—*Nature of Injury*

Contusion	30.1%
Sprain	25.4%
Strain	21.0%
Fracture	9.4%
Dislocation	5.4%
Concussion	4.7%
Others	3.2%

The results are seen in Table 3. Overall, 26% of the injuries occurred on artificial surface, while 71% occurred on grass. The condition of the surface was dry in 90% of the injuries.

We also evaluated the quarters of the game and the hour of practice when the injury occurred. The results are seen in Table 4.

Next we turned to the type of injury and the body part involved. These are seen in Table 5 and Table 6. Finally we attempted to determine the incidence of the major injuries of fracture, dislocation and severe sprain or strain by careful site as shown in Table 7.

Table 6.—*Site of Injury*

Hand/Finger	16%
Knee	13%
Ankle	12%
Shoulder	10%
Upper Leg	10%
Lower Leg	8%
Back	5%
Head	4%
Forearm	4%
Elbow	3%
Neck	2%
Pelvis	3%
Others	10%

Discussion

The incidence of injury occurring while participating in football at the high school level has generated nationwide concern. In attempt to assess the situation in the State of Hawaii, all schools were asked to participate in a prospective survey for the 1979 season. Unfortunately, only 24 schools responded and several of those only periodically. This difficulty we encountered points out the problem of getting data on athletic injuries in Hawaii. There is not a good school reporting system. Some coaches we talked to felt that this was a real problem with their program. A second major problem we encountered was the lack of medical help available for the public schools in the State. When we inquired about

Table 7.—*Type of Serious Injury by Site*

	FRACTURE	DISLOCATION	SPRAIN/STRAIN
Hand/Finger	20	7	58
Knee	4	4	71
Ankle	7		94
Shoulder	5	9	20
Upper Leg	0		48
Lower Leg	8		18
Back	1		15
Head	2		—
Forearm	6		5
Elbow	4	5	10
Upper Arm	2		2
Neck	0		17
Foot-Toe	1		11

who was responsible for the injuries in their program, the answer varied from no one to the school nurse or even the family physician. Coaches often had to make their own arrangements for medical coverage at games; almost none had any coverage during practices, when half of all injuries occurred. In the private schools, athletic trainers were available at practice as well as games. Therefore, the reporting of injuries was superior in the private schools. In interviewing several of the athletes at private and public schools, it was also evident that the presence of a trainer facilitated the ease of an athlete obtaining care.

Even with these concerns, it is apparent from our study that there are a number of significant injuries in Hawaii. There were 462 injuries that caused the athlete to miss at least a game or two practice sessions. The remainder could be classified as minor, although they often prevented the athlete from performing at best level. Fractures and dislocations comprised 13.8% of all injuries. The figure is comparable to the data reported in other students[5] and points out the significance of these injuries as part of high school football. Fortunately, we had no serious head or neck injuries resulting in paralysis or deaths in 1979.

As a result of our survey, we can make several other conclusions. First, the incidence of injury is greatest in the early part of the season, in the second hour of practice or second quarter of a

game. Secondly, blocking and tackling are the most common causes of injury, comprising 47% of the total. It was interesting to note that 11% of the injuries occurred with no contact. These were almost all limited to the knee and ankle.

Although it was difficult to analyze, it appears that the ratio of injury varied from 2-1 to 4-1 when comparing natural to artificial turf. However, when the total number of games played by the schools is analyzed, it is difficult to correlate this information, since over 75% of all of the games reported were played on grass or dirt.

Although this study is inconclusive, it points out that we do have a significant number of football injuries in the State and that some of these are serious.

Summary

The results of a survey of 885 football injuries occurring in 24 Hawaiian high schools for the 1979 year are presented. These injuries were analyzed by a variety of parameters to attempt to understand them better. The significant finding was the reporting problem of schools without athletic trainers.

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New help for platelets . . .

Use of Vinblastine-Treated Platelets in Drug-Immune Thrombocytopenia

ROBERT T.S. JIM, M.D.

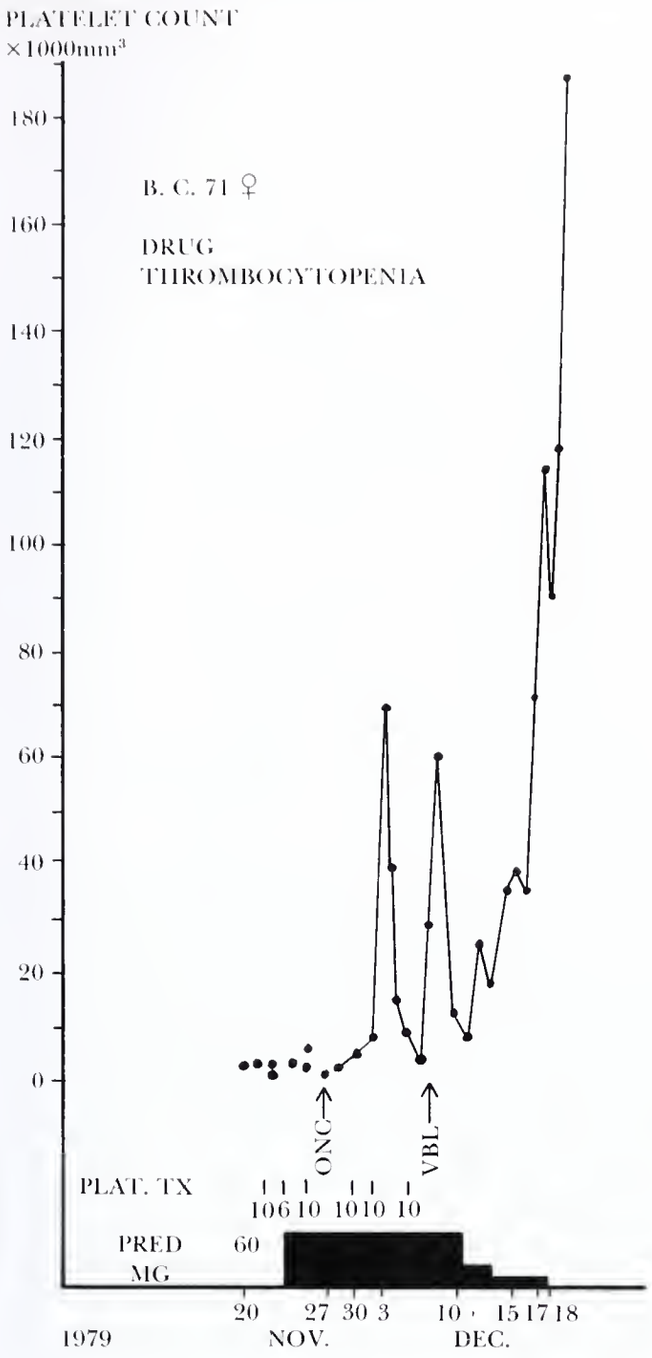
Infusion of vinblastine-treated platelets (VBP) may be beneficial in idiopathic thrombocytopenic purpura[1]. It may also be useful in drug-immune thrombocytopenia.

CASE 1. A 71-year-old woman developed ecchymoses, nasal, gastro-intestinal and vaginal bleeding after taking spironolactone, hydrochlorothiazide, theophylline, hydroxyzine HCl, ephredrine, tolmetin sodium, disopyramide phosphate for asthma, hypertension, and osteo-arthritis. Complete blood count revealed RBC 2.30 million/mm^3, hemoglobin 6.7 g/dL., WBC 10,400/mm^3, MCV 89 microns, MCH 29.3 micromicrograms, MCHC 32.6 g/dL., differential smear with neutrophils 44, bands 24, metamyelocyte 1, lymphocyte 6, monocytes 7, eosinophils 18 per cent and 1 nucleated RBC/100 WBC. Platelet count was less than 3000/mm^3, partial thromboplastin time 24.5 s (normal under 38 s), prothrombin time 11.5 s (normal control 11.5 s). The medications were discontinued and prednisone 60 mg daily started on November 23, 1979, 6 to 10 units of platelets given daily for 6 days 4 units of packed red cells given. On November 26, vincristine, 2 mg. i.v., was given, with transient rise in platelet count to 69,000/mm^3. On December 5, 5 units of VBP platelets (1) were given followed by rapid rise in platelet count to normal by December 19 (see Figure 1).

CASE 2. A 74-year-old man developed pancreatitis in January, 1980, followed by complications of recurrent pancreatic pseudocysts, intra-abdominal and sub-phrenic abscesses, and fistula formation, requiring many surgical drainages. When seen on July 29, 1980, he had ecchymoses and bleeding at the sclerae, tracheostomy and venipuncture sites. He was on cimitidine, ampicillin, cefoxitin, gentamycin, ticarcillin, insulin, furosemide, acetazolamide, digoxin, hydroxyzine, diazepam and methyl prednisolone sodium succinate. Hemoglobin was 9.8 g/dL., WBC 6800/mm^3, differential smear showed a left shift, platelet count was 6000/mm^3,

Accepted for publication February, 1981.

FIGURE 1.—*Use of Vinblastine-treated Platelets in Drug Immune Thrombocytopenia*



prothrombin time 16 s (normal control 11.5 s), partial thromboplastin time 31 seconds (normal control 38 s), plasma fibrinogen 270 mg, plasma protamine precipitation test was positive, fibrin split products positive at 1:10, but negative at 1:40 dilution. He was given 10 units of platelets daily between July 25 and 30 with only transient elevation of the platelet count. On August 2, he was given 5 units of VBP (1), followed by a rapid rise in platelet count to normal 11 days later (see Figure 2).

Discussion

In two patients in which drug-immune thrombocytopenia was thought to be the major pathogenic factor, numerous daily platelet transfusions and steroids failed to increase the platelet counts. Infusion of VBP rapidly increased the platelet counts within 3-4 days in both patients, with complete recovery from the thrombocytopenia. The pathogenic mechanism for drug-immune thrombocytopenia may be similar to idiopathic thrombocytopenic purpura. For persistent refractory drug-immune thrombocytopenia unresponsive to steroids and platelet transfusions, the infusion of VBP may be of benefit, as in chronic idiopathic thrombocytopenic purpura.

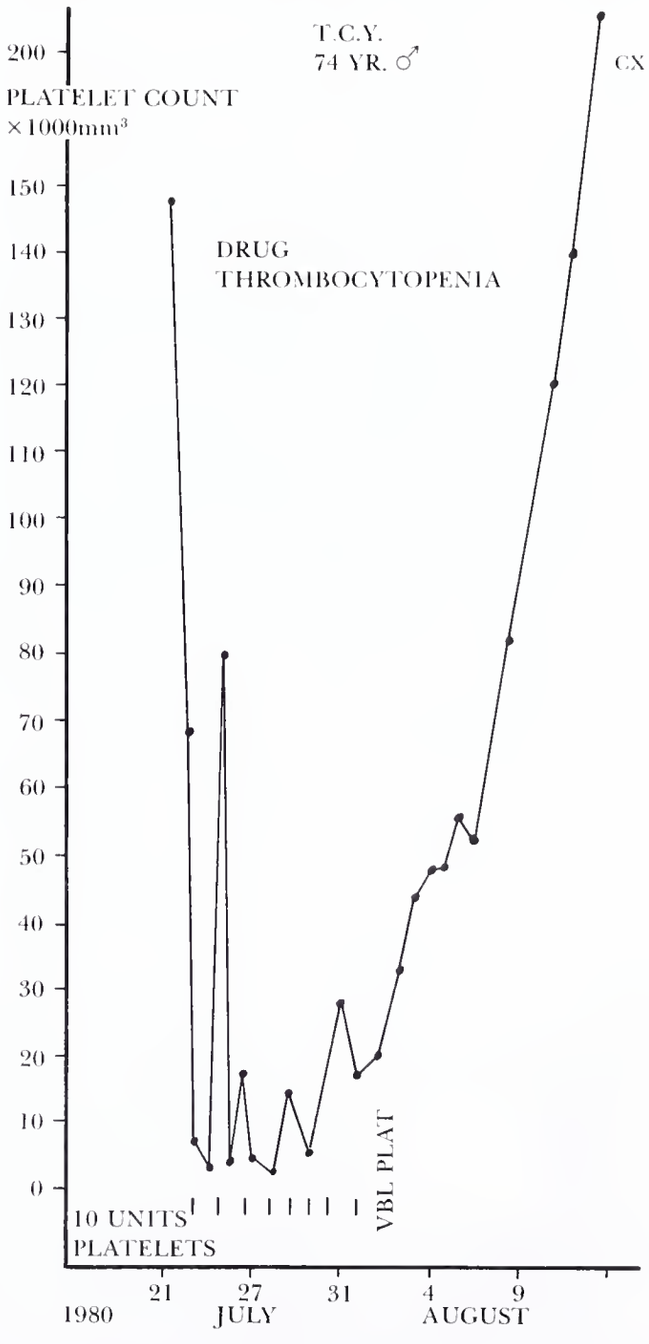
Summary

The use of vinblastine-treated platelets in two patients with drug-immune thrombocytopenia, unresponsive to steroids and platelet transfusions resulted in rapid return of platelet counts to normal. Infusion of vinblastine-treated platelets may be beneficial in drug-immune thrombocytopenia.

REFERENCES

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FIGURE 2.—*Use of Vinblastine-treated Platelets in Drug Immune Thrombocytopenia*



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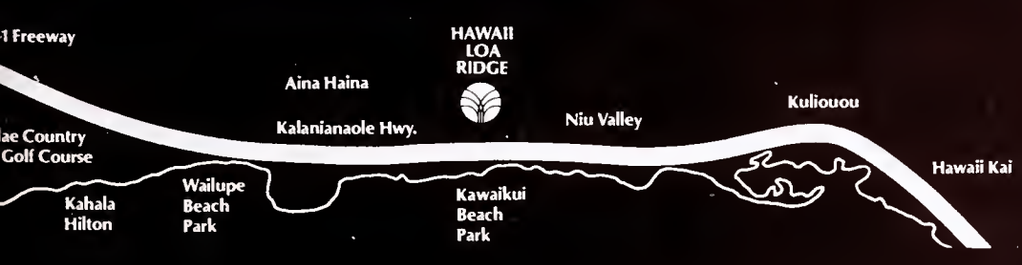
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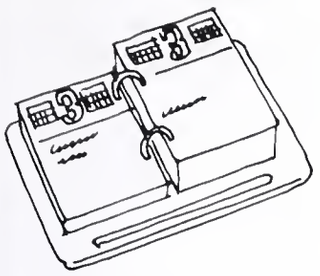
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ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G. N. Wilcox Memorial Hospital, First Thursday, 12:45 p.m. and Fourth Tues. 12:30 p.m. w/Maui Mem. Hsp. Held on Oahu at Am. Cancer Society main conf. room, 200 N. Vineyard, Honolulu.

John A. Burns School of Medicine

1. Dept of Medicine
 - A. Case Conferences, Second and Fourth Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 - B. Grand Rounds, First and Third Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 - C. Endocrinology Grand Rounds, Third Wednesdays, 5:30-6:30 p.m., Queens University Tower, Room 506.
 - D. Hematology Grand Rounds, Second and Fourth Mondays, 12:30-1:30 p.m., Queens University Tower, Room 721.
 - E. Cardiology Grand Rounds, First and Third Tuesdays, 5:30-6:30 p.m., Queens University Tower, Room 508.
 - F. Infectious Disease Grand Rounds, Second and Fourth Tuesdays, 5:00-6:00 p.m., Queens Nalani 1 Conference Room.
 - G. Dermatology Grand Rounds, Second Wednesday, 7:30-8:30 a.m. Queens, Queen Emma Clinic.
 - H. Pulmonary Grand Rounds, Second and Fourth Thursdays, 4:30-5:30 p.m., Queens Kamehameha Auditorium.
2. Division of Nuclear Medicine
 - A. Technical aspects of Nuclear Medicine, Second Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506, 1½ credits.
 - B. Rounds, Fourth Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506.
3. Dept. of Obstetrics and Gynecology
 - A. Grand Rounds, Wednesday 7:30-8:30 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
4. Division of Orthopaedics
 - A. Fracture Conference, Tuesdays, 5:00-6:00 p.m., Queens University Tower, Room 618.
 - B. Shriners Hospital Conference, Tuesdays, 7:15-9:15 a.m., Shriners Hospital.

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 B. Pediatric Conference, Mondays 12:45-1:45 p.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 C. Pediatric Infections Disease Conference, Thursdays, 12:30-1:30 p.m., Kapiolani-Children's Medical Center, Third Floor Conference Room.
 D. Neonatal Ground Rounds, Fridays, 8-9:00 a.m., Kapiolani-Children's Medical Center, Administrative Conference Room.
6. Dept. of Psychiatry
 A. Grand Rounds, Fridays 8:00-9:30 a.m., Queens University Tower, Room 618.
7. Dept. of Surgery
 A. Grand Rounds, First, Second and Third Saturdays, 7:30-9:00 a.m., rotating hospitals.
 B. Statistical M and M, last Saturday, 7:30-9:00 a.m., rotating hospitals.
 C. Journal Club, First and Third Tuesdays, 6:00-8:00 p.m., Queens University Tower, Room 620.
 D. Medical-Surgical G.I. Rounds, Second Tuesday, 7:00-8:00 a.m., Queens University Tower, Room 506.
8. Depart of Family Practice
 A. Conf., Wednesdays, 8-9:00 a.m. Kaiser 4th Floor Conf. Room.
 B. Conf., Thursdays, 12-1:00 p.m. Kaiser 4th Floor Conf. Room.
9. Department of Physiology
 A. Dept. Conf., Wednesday, 4:30-5:30 p.m. BioMed T-210.
10. University of Hawaii, John A. Burns School of Medicine Grand Rounds, Third Thursday, 4:30-6:00 p.m., Queen's University Tower, Room 618 or BioMed Building.
11. HI Oncology Group, one Monday a mnth., 12:30-1:30 p.m., The Cancer Center, 1236 Lauhala St., 4th Floor Conference Room.

Federation of Emergency Medicine-Maui

1. **Cardiology for the Emergency Physician.** Every Monday, 9-10:00 a.m.-Maui Memorial Hsp. Conf. Rm #1. (For spec. topics or further info. contact: Federation Office (808) 244-7629, or Dr. C. T. Mitchell, (808) 244-9056.
2. **Journal Club in Emerg. Medicine.** 2 hrs. Cat. I. MMH Conf. Rm. #1. 9am-11 a.m.
 8/24/81 Annals in Em Med, 4/81; Abstracts in EM 5/81 - D. King
 9/21/81 Annals in Em Med, 5/81; Abstracts in EM 6/81 - S. Burkle
 10/19/81 Annals in Em Med, 6/81; Abstracts in EM 7/81 - P. McCallum
 11/23/81 Annals in Em Med, 7/81; Abstracts in EM, 8/81 - J. Mills
 12/21/81 Annals in Em Med, 8/81; Abstracts in EM, 9/81 - C. Mitchell

Hawaii Thoracic Society

1. Pulmonary Med., Clinical case presentations & current research in pul. med. with U of H Sinclair Chest Club. Third or Fourth Wed., ea month, 7:30 p.m.-9:30 p.m. For further info contact: Rosemary Respicio, B.S.N. at (808) 537-5966.

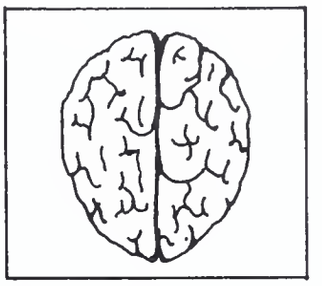
Hickam Clinic

1. Clinical Correlation Conference, First Thursday, 11:00 a.m.
2. Didactic—our staff, Second Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, Third Thursday, 11:00 a.m.
4. Radiology Conference, Fourth Thursday, 11:00 a.m. (Contact Aurora Macapinlac, M.D., M.C., 449-5770)

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H.R. Tyler, M.D., Professor of Neurology, Harvard Medical School, Boston, Mass.

Registration Fee: $175

For information, please write:

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Office of Medical Administration
Straub Clinic & Hospital, Inc.
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This seminar is acceptable for 12 credit hours, Category I, towards the AMA and AAFP certificates in Continuing Medical Education.

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Hilo Hospital

1. Orthopedic Conference, First Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, Second Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, Third Friday, 12:30-1:30 p.m.
5. C.P.C., Second Friday, 12:30-1:30 p.m.
6. Visiting Professor's Program

Kaiser Hospital

1. Medicine Grnd. Rnds. Every Tues. 8 a.m. Pac. Aud. 1 hr. Cat. I.
2. Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. I.
3. OB/Ped. Perinatal Mortality Conf. Last Tues. ea. mnth. 8:00 a.m. 1 hr. Cat. I.
4. Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. I.
5. Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. I.

(Contact CME Dept.-Kaiser for further information)

Kapiolani-Children's Medical Center

1. Pediatric Grnd. Rnds. Every Thursday, 8-9:00 a.m. Aud.
2. Pediatric Conf. Mondays, 12:45-1:45 p.m. 2nd Floor Aud.
3. Neonatal Grnd. Rnds., Fri. 8-9:00 a.m., Conf. Rm. B.
4. Pediatric Infectious Disease Conf., Thursdays, 12:30-1:30 p.m. 3rd Floor Conf. Rm.
5. Ob-Gyn Conf. Tues. 1-2:00 p.m. Aud.
 First—Didactic Presentation
 Second—Perinatal-Neonatal Topics
 Third—Obstetrics Topics
 Fourth—Gyn Topics
6. Tumor Brd.—Oncology Conf. First and Third Fri. 1-2:00 p.m., Aud.

Kuakini Medical Center

1. Department of Ophthalmology Mtg., First Tuesday, 12:30-1:30 p.m.
2. Department of Medicine Mtg. (Statistical), Fourth Tuesday, 1:00-2:00 p.m.
3. G.I. Conference, First Tuesday, 8:00-9:00 a.m.
4. Nephrology Conference, First Wednesday, 8:00-9:00 a.m.
5. Oncology Conference, every Thursday, 7:30-8:30 a.m.
6. Pulmonary Conference, First Thursday, 1:00-2:00 p.m.
7. Surgical Conference First & Second Friday, 12:45-1:45 p.m.
8. Surgical M & M Conference, Fourth Friday, 12:45-1:45 p.m.
9. Department of Medicine Evening Mtg., Second Tuesday, 5:30-7:00 p.m.
10. Visiting Professor Program (for further info. contact CME Dept. 547-9226 as these programs may be subject to change.)

Maui Memorial Hospital

1. Thurs. Conf. 7-8:00 a.m. Staff Dining Rm.
 1st—Dept. of Medicine
 2nd—Dept. of Surgery
 3rd—Dept. of OB/GYN
 4th—Dept. of Pediatrics
 5th—Elective
2. Tumor Brd. every Mon. 12:15-1:15 p.m.—Tumor Conf. Telephone Task Force—Third Tues. 12:15-1:15 p.m.
3. Dept. of Emergency Med., Third Mon., 7-8:00 a.m.
4. Diagnostic Radiology—Fourth Tues., 12-1:00 p.m.
5. SFH-UH Hematology Conf., Third Thursday, 12:30 p.m.Sullivan-4 Classroom.
6. SFH-UH Surgical Grand Rounds, First, Second, & Third Fridays, 7:30 a.m., Sullivan-4 Classroom.
7. Visiting Professor Programs (for further infor call CME office at St. Francis).

The Queen's Medical Center

1. ENT Conferences, First and Second Fridays, 7:30 a.m., Small Dining Room.
2. Medical Conferences, Every Friday, 8:00 a.m., Kam Auditorium.
3. Ob/Gyn Conferences, Second and Fourth Mondays, 1:00 p.m., Kam Auditorium.
4. Ophthalmology Conference, Fourth Tuesday, 5:00 p.m., Queen Emma Eye Clinic.
5. Orthopaedic Conferences, Every Wednesday, 7:00 a.m., Kam Auditorium.
6. Pathology Conferences, Every Wednesday, 7:30 a.m., Surgical Conference Room.
7. Pediatric Grand Rounds, Fourth Thursday, 12:30 p.m., Nalani I Conference Room.
8. Surgical Trauma Conference, Second Tuesday, 4:30 p.m., Kam Auditorium.

 Basic Science Lectures, Every Wednesday, 7:15 a.m., Queen's University Tower, Room 618.

St. Francis Hospital

1. SFH-UH Tumor Conf., Every Monday, 7:30 a.m. Sullivan-4 Classroom.
2. SFH-UH Nephrology Conf., First Monday, 1:00 p.m. Sullivan-4 Classroom.
3. SFH-UH Endocrine Conf., last Monday, 12:30 p.m. Sullivan-4 Classroom.
4. EENT Meeting, First Tuesday, 7:00 a.m., Sullivan-4 Classroom.
5. SFH-UH Hematology Conf., Third Thursday, 12:30 p.m. Sullivan-4 Classroom.
6. SFH-UH Surgical Grand Rounds, First, Second, & Third Fridays, 7:30 a.m., Sullivan-4 Classroom.
7. Visiting Professor Programs (for further info call CME office at St. Francis).

Straub Clinic & Hospital

1. Straub Professional Seminar meets the Second Tuesday of each month, from 5:00-6:30 p.m. in the Credit Union Meeting Room (2nd Floor, Credit Union Bldg).
2. Surgical Mortality and Morbidity Conference meets every Fourth Thursday of each month, from 7:00-8:00 a.m. in the Doctors' Dining Room.
3. Cardiac Surgery Conference meets the Third Tuesday of each month, from 4:30-5:30 p.m. in the Doctors' Dining Room.
4. Department of Anesthesiology meets the Second Tuesday of each month from 7:00-8:00 p.m. in the Doctors' Dining Room.
5. Community Peripheral Vascular Conference meets the Fourth Thursday of each month from 5:00-6:30 p.m. in the Doctor's Dining Room.
6. Visiting Professor Program meets monthly from 7:00-8:00 a.m. in the Doctors' Dining Room.
7. Urology Inservice meets every other month on the Third Friday from 8:00-9:00 a.m. in the Doctors' Dining Room.
8. Neuropathology Clinical Correlation Conference meets the Third Thursday of each month from 7:30-8:30 a.m. in the Straub Morgue.
9. OB-GYN Pathology meets every Fourth Monday of each month from 12:30-1:30 p.m. in the Administration Conference Room (ACR).
10. Urologic Pathology meets every First Monday of each month from 8:00-9:00 a.m. in the Doctors' Dining Room.
11. Friday Noon Conference meets every Friday of each month from 12:30-1:30 p.m. in the Doctors' Dining Room.

*Note: All conferences are subject to change. Monthly calendar will be available upon request.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—last Wednesday

2. General Medical Staff Meeting—Second Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Miscellaneous

HMA Maternal and Perinatal Mortality Study Cmte. First Monday ea. month-5:30 p.m. 320 Ward Ave., S 200. Cat. I on hr. for hr. basis.

SPECIAL EVENTS

July 31, Aug 4, 1981	ACP Internal Medicine Update, Spons: ACP & J.A. Burns Schl of Med, Honolulu, Contact: Dee Chang (808) 947-8573. Held: Wailea Beach Htl, Maui.
Aug 7, 8, 1981	Ophthalmology Annual Mtg., Alumni U of CA Irvine Coll. of Med., Irvine, CA. Held: Kona, HI.
Aug 15, 26, 1981	24th Annual Postgraduate Refresher Course, USC School of Medicine in assoc. with TAMC, Honolulu and Maui, up to 37 hours, $375 tuition.
Aug 25, 26, 1981	Gynecological Urology: A Teaching Course, Sheraton-Waikiki, UC Irvine, Jack R. Robertson, 1430 E. Main St., Santa Maria, CA 93454.
Aug 26, Sept. 7, 1981	Third Ann. Radiology for Nonradiologists. San Diego Rad. Res. & Educ Found, Box 2305, LaJolla, CA. 92038; cospons: Am Col of Radiology. Held; Kauai Surf Resort Htl, Kauai. 35 hrs. Cat. I.
Aug 29-Sept 4, 1981	Concepts in Infertility-1981, Royal Lahaina, Maui, Stanley Friedman, The Edward Tyler Medical Clinic, 921 Westwood Blvd., LA 90024.
Oct. 7-9, 1981	"Current Neurology." Straub Clinic & Hsp. Held: Honolulu Art Academy Aud, 900 S. Beretania, Honolulu. Contact: Off. of Med. Admins., Straub, 888 So. King St. Honolulu, 96813; (808) 523-2311.
Oct 12, 16, 1981	Oncology Board Review, Princess Kaiulani, ACP, Dr. Thomas Hall, Cancer Center of Hawaii, 1236 Lauhala, Honolulu 96813.
Oct. 12, 16, 1981	AMA Regional & Scientific Mtg/HMA Annual Mtg. Held: Ilikai Htl, Waikiki. Contact: AMA Dept. of Mtg. Serv.; 535 No. Dearborn St., Chicago, IL 60610.

OUT OF STATE

For information on any out-of-state programs or courses, refer to September 3, 1980 Supplement to JAMA or call the HMA Office.

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Increasing Professional Fees

"We had to raise our fees 14% again this year, to match our increased costs," the neurosurgeon told me. His overhead, he was quick to complain, was "almost 50%."

Some quick calculations reveal the fallacies in my friend's argument. If half his income goes to covering costs of practice, and if those costs have increased 14%, he can completely offset these expenses by raising his fees only 7%. By raising his fees to match the percentage of increased costs without regard for overhead *percentage*, my friend unwittingly overcharges his patients by a substantial amount.

The formula for an equitable increase in fees requires three steps. First, take your total *costs* of doing business during the most recent quarter year, for example, and compare this with your gross *income* for the same period, expressing the costs as a percentage of gross. (One method which proves quick and easy is to consult bank statements for total of checks written, then add the quarterly cost of annual items such as insurance or dues; throw in your quarterly salary, too, if you please.) For example, if costs last quarter were $10,000 and income was $18,000, then your overhead is 56% of gross.

Next, compare these current expenses with the cost of identical items during the same quarter *last* year to find the annual percentage of increase. For example, the $10,000 you spent during the recent quarter, compared with perhaps $9,000 for the same period last year, suggests an increase of about 11%.

Finally, multiply the increased expenses (11%) by the portion of gross (56%) needed to cover those expenses. This yields the increase in receipts you'll require to offset increased costs (or 6.2% in our example).

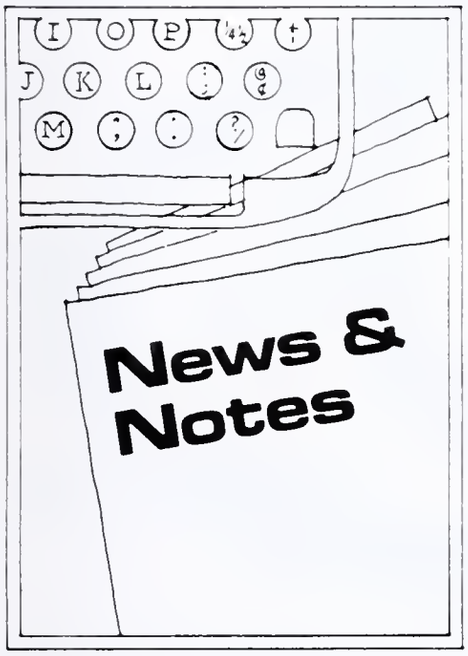
Try the exercise next time you review your fees. You may find you needn't increase your charges so much as you thought. A simple 10%

annual fee increase will double your rates by the seventh year. "But the salaries and rent I pay may double, too!" you wail. Perhaps, but you need only raise your fees by the percentage of income those increases represent, in order to keep current.

Some guidelines for reasonable fee policies would be a helpful service of our Association. As inflation eases, all of us should do what we can to assure that our charges don't prolong inflationary forces more than necessary.

JMC

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HENRY N. YOKOYAMA, M.D.

Of Moles and Melanomas

Richard Dobson, professor and chairman, Department of Dermatology, Medical University of South Carolina, was here in early April and we caught his lecture, "Moles and Melanomas."

"This lecture is worth the plane ticket . . . Melanoma is becoming epidemic . . . When I was a resident I saw 2 cases . . . Last year alone, I saw 200 cases . . . World wide incidence has increased to 300% and mortality has doubled . . . In the U.S. alone, 9,000 new cases of melanoma occur each year . . . There are 300,000 new cases of skin cancer each year in the U.S. which is a 2 or 3 fold increase and makes up ½ of the total cancer cases in the U.S. . . . ⅔ of the deaths from skin cancer are from malignant melanoma . . ."

Re Nevi: General rule: A suspicious nevus is one behaving differently from others . . ."

It's normal for nevi to darken in pregnancy and puberty . . .

10 to 25% of congenital nevi become malignant melanoma . . .

Re Characteristics of Benign melanocytic nevi:
- a. Orderliness of color, margins, surface topography
- b. Presentation of normal skin markings
- c. Size is less than 9 mm . . .

Re Characteristics of Malignant Melanoma:
- a. Irregular coloration with shades of brown, black, tan or red, white and blue
- b. Irregular margins
- c. Irregular surface with loss of normal skin markings . . .

Re Danger Signals: (Irregularity of color, shape, surface)
- a. Change in color, esp red, white, blue
- b. Change in size
- c. Change in superficial characteristics (ulceration is too late)
- d. Change in consistency
- e. Change in symptoms ie itches, hurts
- f. Change in shape
- g. Change in surrounding skin

Re Diagnostic Accuracy (DA): DA% =

Correct Diagnosis × 100

Correct Diagnosis + False Positive + False Negative

At best centers: DA = 60%

"My own DA = 50%"

Re Biopsy Guidelines:
- a. Lesions 5-15 mm diameter: Excise whole
- b. Lesions greater than 15mm or on face: incisional biopsy
- c. Photograph unusual lesions and send photo to pathologist with specimen.

"Remember an occasional correct diagnosis will be life saving . . ."

Visiting Professor

The UH Integrated Visiting Professor in March was **Fred Whitehouse,** chief, Metabolic Diseases Div, Henry Ford Hospital . . . Fred, tall, trim, athletic with short cropped grey hair and horn rimmed glasses, lectured to capacity crowds in a charactistic soft tone . . . His lectures were an admixture of fact and wit . . .

"Pros and Cons of Strict Diabetes Control"

Non-insulin diabetic: a. High quality control should be possible with strict monitoring . . . b. Motivate patient to physical activity, diet and compliance . . . Insulin Dependent diabetic: Major problem . . . May be HLA related.

"In pre-insulin era: the goal was survival . . . 75% of patients died of ketosis and 25% died of infection and starvation . . . Insulin era: (Insulin is the world's best anabolic hor-

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mone) a child could grow; infertible woman became fertile; and quality of life improved . . ."

"Control vs Duration Genetics: microangiopathy tapers off at age 30 at 80% level; macrovascular disease starts later, ie age 25 to 35; retinopathy drops off at age 30 and decreases . . . At present, Honolulu Time, 1981, the answers (re quality control vs Genetic-Duration) are not available. Nothing definitive is known at present . . ."

"Mortality in Diabetes Mellitus: 80% of deaths are cardiovascular renal in nature . . ."

"Metabolic Control and Macroangiopathy: a. Lowers triglycerides b. Raises HDL c. Lowers total cholesterol c. Lowers platelet aggregation d. Normalizes von Willebrand factors . . ."

"Strictest Quality Control: a. Maintain blood sugar at 70-120mg before meals b. Maintain blood sugar at less than 200mg after meals c. Maintain normal wtg slender side d. Keep physically active e. No smoking f. Promote home blood glucose kits g. Take glycolated Hb every 6 months h. High fiber diet i. Use lowest insulin dose and multiple injections of pork insulin . . . Regimen: split dose of regular and intermediate insulin with 5 meals/d . . .

"I think the most practical is to give regular and intermediate insulin twice daily before breakfast and before supper . . . Insulin pumps are still experimental . . ."

Re HDL Cholesterol: "I think alcohol (probably in excess) is the most effective way to raise HDL cholesterol (and the most pleasurable way) . . . A couple ounces before dinner . . . I advise hard liquor or white wine . . ."

"Complications of Diabetes and Their Management"

Five major complications:

a. Acute metabolic: ketoacidosis, hyperlipidemia, hyperosmolarity . . .
b. Microangiopathy: retinopathy, nephropathy, neuropathy
c. Macrovascular: HDL cholesterols, total cholestrol, triglycerides
d. Therapy Complications: esp hypoglycemia in insulin dependent diabetics
e. Emotional Reaction to diabetes: Patient, parent and spouse reactions . . .

"The three most common areas of complications are primarily in small blood vessels . . . ie retinopathy, neuropathy and nephropathy . . ."

Re Retinopathy:

1. Nonproliferative (or background)
2. Proliferative: 1 out of 3 cases result in blindness; benefited by photocoagulation

Re Neuropathy:

1. No good cure at present
2. Types:a. Peripheral sensory neuropathy: legs more than hands; sensory more than motor
 b. Asymmetric neuropathy: sensory-motor
 c. Mononeuropathy
 d. Autonomic neuropathy; neurogenic bladder, impotence

Neuropathy Pearls I:

a. Orthostatic hypotention
b. Diarrhea—normal small bowel biopsy; use of cholestyramine diasappointing
e. Gastric paresis: 1. Avoid antispasmodics
 2. NG suction
 3. Drainage operation
 4. Metapropriomide 5mg/cc
f. Neurogenic bladder: Think of it; void by clock; Foley/suprapubic cystostomy; outlet resection; Betanechol
g. Impotence: artificial devices; time

Nephropathy I:

1. Incidence in US—25-30% of end stage renal disease
 a. JODM=50%
 b. MODM —10%
2. Orthodox Therapy: adjust diet; control hypertension; prevent and correct GU disorder; control salt and water (Use diuretics)

Nephropathy II: Substitute treatment:

a. Dialysis (peritoneal and hemodialysis): after age 40
b. Transplant: before age 40

"Newer Classification and Diagnostic Aspects of Diabetes Mellitus"

Type I IDDM (Insulin Dependent Diabetes Mellitus): Formerly Juvenille DM or Brittle DM

Type II (Non Insulin Dependent DM) NIDDM:
Receptor defect (decreased sensitivity)
Post receptor defect (decreased responsiveness)
Combined group

Type II NIDDM: Non Obese NIDDM
Obese NIDDM

Characteristics: a. After age 40 b. Insulin levels high, low or normal c. Non-ketone prone d. May require insulin for control of symptoms e. 60% to 90% are obese

Other Types of DM: Formerly Secondary DM

1. Pancreatic Disease
2. Hormonal eg Cushings, Acromegaly
3. Drug or chemically induced
4. Insulin receptor abnormalities
5. Genetic syndromes

Metabolic or Gestational Diabetes:

FBS	105	100 gm oral glucose load; 2 or more venous glucose levels must be higher
1°	190	
2°	165	
3°	145	

National Diabetes Data Group Classification of Glucose Tolerance

Clinical Classification:
Type I
Type II
Other Types: Pancreatic
Hormonal
Drug or Chemical Induced
Insulin Receptor Abnormalities
Certain genetic syndromes

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Complications of DM: Biochemical: Hyperglycemia; hypoglycemia; hyperilpoprotenemia
Anatomical: Angiopathy; neuropathy; nephropathy; retinopathy

"Diabetes is very old . . . Nothing has changed . . . It is we who change . . ."

Re Side Effects of Oral Agents: 3-6% have reaction eg nausea and vomiting—Dilutional hyponatremia

70-80% of patients on oral agents return to normal glucose levels

Diabinese: 36 hr action (½ live longer than 24 hr) 1 tab daily

Dymelar: 18 hr action (Give twice daily) Metabolites are 2½ times more potent.

Tolinase: Give twice daily

Tolbutamide: 8 hr action . . . Give 2-3 times daily

UGDP Study (One of the great debacles of modern clinical research)

Proved: 1. Diet was better than insulin therapy
2. Orinase causes more cardiovascular complications in a few patients

Pros and Cons: Over a 10 year period, 250 articles appeared and only 2 articles out of the 250 were valid . . .

Basically I look on this controversy thusly: We have 6,000 diabetics in LA County:

¼ of the patients are on diet alone

⅓ to ½ of the patients are on oral agents

The rest are on insulin (viz Juvenile, Type II, Type IIA)

Other Gems: Exercise increases the number of insulin receptors

Most of our insulin patients are on one injection of NPH . . . Sometimes we mix regular with NPH, or give NPH bid . . .

Criteria for starting oral agents: We start with diet for 1-2 months and if FBS is still greater than 130, then we give Diabinese 100 to 250mg once daily. We try to keep FBS at 110mg% . . .

The general feeling is that hyperglycemia of aging is also associated with increased risk factors . . .

Life In These Parts

A 77-year old Japanese man with a chronic cough and a 15-lb. weight loss in 4 months was a 2-pack smoker till recently. He was found to have a RLL mass on chest Xrays. Bronchoscopy biopsy revealed inflammatory tissue but no tumor cells. The chest surgeon was forced to explore and do a lobectomy despite the patient's diminished pulmonary reserve . . . The mass grossly felt like tumor, looked like tumor, even smelled like tumor, but the pathologist called it "pseudotumor . . ." We asked amiable pathologist **Larry McCarthy,** "How do we treat pseudotumor . . ." Larry's eyes twinkled as he smiled his shy smile and said, "With pseudotreatment." . . . And we smiled happily too . . . with relief . . .

Professional Moves

In Honolulu, general surgeon **Bradley Wong** joined George Nip MD Inc. at Queen's POB Suite 707; neurosurgeon **Gonzalo Chong** and gastroenterologist **Sam Sue** joined the Straub Clinic; ophthalmologist **David Randell** opened at 45-955 Kam Hwy Suite 405, Kaneohe; internist **Glenn Uto** opened at Kuakini Medical Plaza, Suite 607, medical oncologist **Melvin Inamasu** joined the Hematology-Medical Oncology Associates Inc. at Medical Arts Building and Aiea Medical Building; psychiatrist **Arnold Golden** opened at Room 395, Alexander Young Building and **R. Reginald Patterson MD Inc.** moved to Pearlridge Office Center Suite 811.

On Maui, internist-oncologist **Gregory Park** associated with **William James** at the Maui Clinic, 53 Puunene Ave., Kahului and **Darnell Richey** opened his office at the Wailea Shopping Village, Wailea Resort, Kihei, Maui. On the Garden Isle, internist **Glenn Yoneda** joined the Kauai Medical Group, internist **Thomas Harrison** joined the Kalaheo Clinic, and three physicians who are also members of the Kauai Medical Group joined the Wilcox Hospital staff viz surgeon **Robert Teichman,** radiologist **Harvey Nakamura** and OB Gyn man **Cheston Reed** . . . On the Big Island, surgeon and GP **Gunars Medins** who has been practicing in Africa and Micronesia has reopened his office in Kona.

In early September, **Michael Light** who specializes in pediatric pulmonary and intensive care medicine, joined **Stuart Rusnak** in Suite 1030 Kapiolani Children's Medical Center, internist-endocrinologist **William Martin** joined The Fronk Clinics, **Harry Nakata, MD Inc.** relocated to Suite 703, Medical Arts Building. On the Big Island, FP **Richard Lee Ching** joined the Hilo Medical Group, Inc. at 1292 Waianuenue Ave., Hilo.

MAE WEST'S WITTICISM . . .

(Gleaned from a Dec 1 1980 issue *Time* magazine article by Gerald Clarke)

"Glamorous, sexy and very very funny" . . . Mae West did not invent sex . . . She just saw the humor in it and no one before or since has had more fun on what she called the 'linen battle field.'"

"I kid sex . . . I take it out into the open and laugh at it . . . I'm a healthy influence."

"Goodness, what lovely diamonds," says a hat check girl. "Goodness" retorts Mae, "had nothing to do with it dearie."

"She's the kind of girl who climbed the ladder of success wrong by wrong."

"A man in the house is worth two in the street."

"It's better to be looked over, then overlooked."

"There are no good girls gone wrong; there are bad girls found out."

"Women are as old as they feel—and men are old when they lose their feelings."

"A thrill a day keeps the chill away."

"Anytime you got nothing to do—and lots of time to do it—come on up."

Ribald Jokes

(As told by our friend and eminent professor of entomology Wally Mitchell)

Comparative Geography . . .

Between ages 15 to 20, a woman is like Africa—partly virgin and partly developed . . .

Between ages 21 to 35, she is like Asia—hot and exotic . . .

Between ages 36 to 45, she is like the U.S.—overly developed, fully explored and still free with her resources . . .

Between 45 to 55, she is like Europe—exhausted, but yet interesting in places . . .

After 56, she is like Australia—everyone knows what's down there, but no one gives a damn . . .

The Angels and the Nuns . . .

Two angels were kicked out of Heaven for trying to make a prophet . . .

Three nuns arrived at Heaven's pearly gates and were confronted by St. Peter. Peter asked the first nun, "Who was the first man?" "Adam" she replied correctly and was permitted to pass through . . . The second nun was asked, "Who was the first woman?" The nun replied brightly, "Eve." "You may pass," said Peter. He turned to the last nun, "What did Eve say to Adam?" The nun was visibly shaken and mumbled, "Chee, that's a hard one." "Correct! You too may pass through."

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Miscellany

The burlesque theater was running into hard times . . . It needed a gimmick . . . This was in the days of giveaways e.g., the $64,000 question etc etc.The theater owner advertised, "$1000 prize for guessing the name of the song as demonstrated by our girls." Each night the theatre was filled with eager patrons trying to guess the name of the song and night after night no one was able to come up with the answer. Sixteen weeks had passed and the prize was now $16,000 for guessing the name of the song . . . "Ladies and gentlemen! Our ladies will now act out the name of a song and if you guess correctly, you win $1600!" announced the MC. A dancer crossed the stage with her bared fanny towards the audience. She was followed by another dancer with her bosom exposed as she crossed the stage. A repeat of the fanny and the bosom. Then three dancers with bare fannies crossed the stage . . . "I got it!" yelled someone in the audience . . . The MC beckoned, "The gentleman in the balcony! What is the name of the song?" "The William Tell Overture!" exulted the man in the balcony . . . "Anyone knows that it goes, rump-teety! rump-teety! rump! rump! rump!"
(As told by our entomologist professor friend, *Wally Mitchell*).

On Nurses . . .

They say nurses make lousy lovers . . . They've been taught to wait till the tumescence goes down . . .



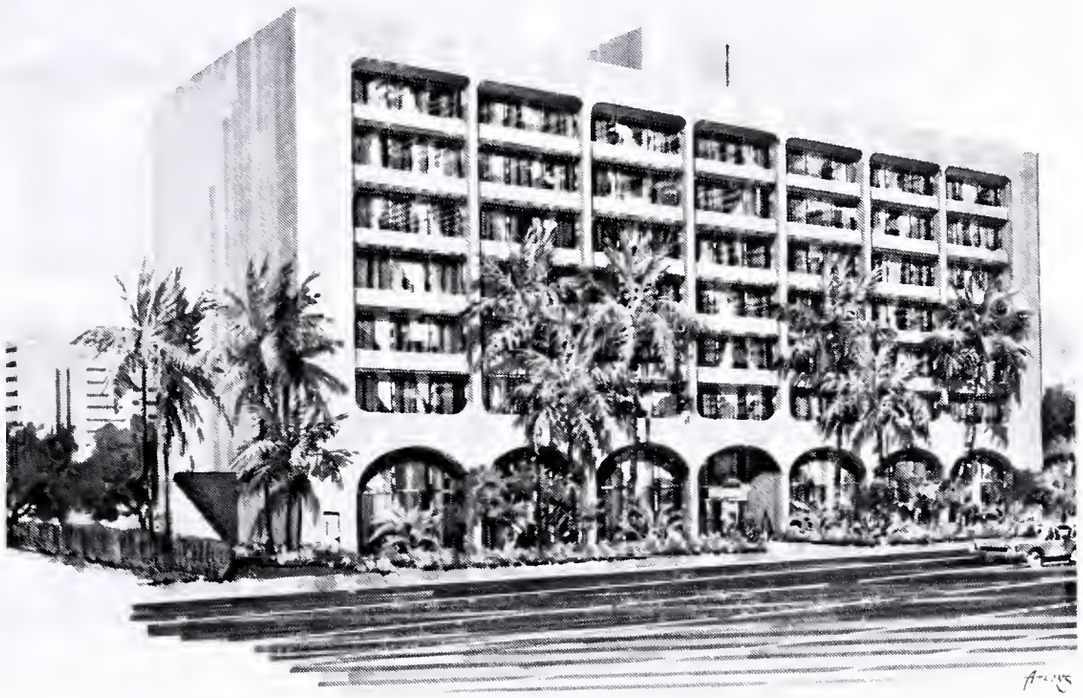
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Feelings vs.

Some people feel that I am misused and overused and that I'm prescribed too often and for too many kinds of problems.

The FACT is that approximately eight million people, or about 5 percent of the U.S. adult population, will use me during the current year. By contrast, the national health examination survey (1971-1975) found that 25 percent of the U.S. adult population experiences moderate to severe psychological distress. Additionally, studies of patient attitudes revealed that most patients have realistic views regarding the limitations of tranquilizers and a strong conservatism about their use, as evidenced by a general tendency to *de*crease intake over time. Finally, a six-year, large-scale, carefully conducted national survey showed that the great majority of physicians appropriately prescribe tranquilizers.

Some people feel that patients being treated with anxiolytic drugs are "weak," can't tolerate the anxieties of normal daily living, and should be able to resolve their problems on their own without the help of medication.

The FACT is that while most people can withstand normal, everyday anxieties, some people experience excessive and persistent levels of anxiety due to personal or clinical problems. An extensive national survey concluded that Americans who do use tranquilizers have substantial

Facts

justification as evidenced by their high levels of anxiety. It was further noted that antianxiety drugs are not usually prescribed for trivial, transient emotional problems.

Some people feel afraid of me because of the stories they've heard about my being harmful and having the potential to produce physical dependence.

The FACT is that there are thousands of references in the medical literature documenting my efficacy and safety. Extensive and painstakingly thorough studies of toxicological data conclude that I am one of the safest types of psychotropic drugs available. Moreover, I do not cause physical dependence if the recommended dosage and therapeutic regimen are followed under careful physician supervision. However, I can produce dependence if patients do not follow their physicians' directions and take me for prolonged periods, at dosages that exceed the therapeutic range. Patients for whom I have been prescribed should be cautious about their use of alcohol because an additive effect may result.

Many of the most knowledgable people feel that I became the No. 1 prescribed medication in America because no other tranquilizer has been proven more effective. Or safer.

The FACT is they are right.

For a brief summary of product information on Valium (diazepam/Roche) ℞, please see the following page. Valium is available as 2-mg, 5-mg and 10-mg scored tablets.

Valium® (IV)
diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal, adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: **Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults*: Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d., alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d., adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients*: 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children*: 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
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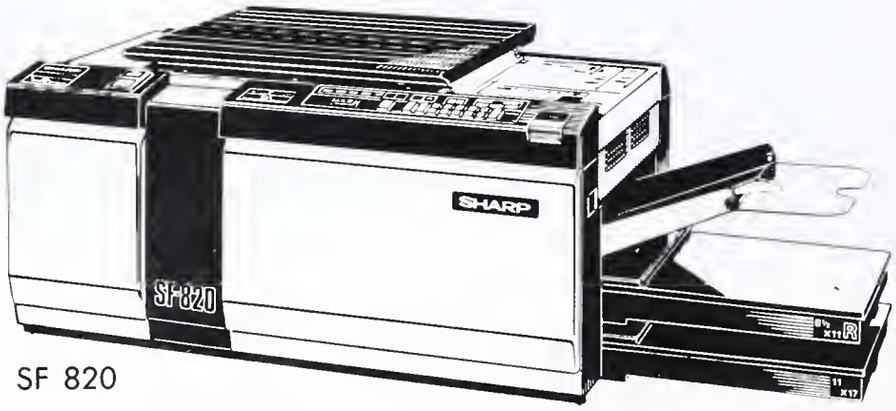






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Editorials

The Howzit Family — Welcome!

With this issue of the JOURNAL, you get a copy of *The Incredible Adventures of the Howzit Family*, a comic book approach to teaching people about skin cancers, including melanomas, and their relationship to sunlight. Please, at least, leave this copy in your waiting room for patients to see; if you'd like additional copies to distribute, call 524-1234. They're free.

The booklet was produced by the staff of the Skin Cancer/Melanoma and Education Program of the Community Cancer Program of Hawaii, located at the Cancer Center of Hawaii. The drawings, which are colorful, vigorous, and topically Hawaiian, are by Harry Lyons. The message is delivered loudly and clearly: sunlight causes skin cancers, including melanomas, and sunscreens can help to prevent them. The advice is specific, correct, and useful, and the messages are vivid. They're even fun to read, as messages must be nowadays if the public is to pay any attention to them.

With the astonishing unprecedented increase in the true incidence of melanoma that has been going on in the past decade, and the sunspot increase in 1981, there could hardly be a more appropriate time for you to participate in this worthwhile educational effort in preventive dermatology.

HLA Jr.

Gasoline and Silver

Thirty years ago, our coins were made mostly of silver and our dollars were certificates redeemable for real metal. You could buy a gallon of gasoline with a twenty-five cent piece in the early 50's.

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If you have one of those real quarters of a generation ago, it will buy *more* than a gallon of gas today; your quarter contains about 2.25 "dollars" of silver money. So you can actually get more gasoline for your silver money today than thirty years ago. Despite what you'd have thought, the true price of gas (in real money terms) has actually fallen.

Put another way, your silver quarter has held its value. It's only our legal tender that's losing value: it takes nine "token" quarters to buy one "real" quarter. Perhaps it's wise to consider our currency as carnival scrip: having face value for a limited period, intended to be promptly exchanged for goods or services, worthless if saved.

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Pre-Hospital Ambulance Utilization of the MAST Garment in Honolulu During 1978

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The medical antishock trouser (MAST) garment is an inflatable external circumferential suit, which has been utilized in operating rooms, in intensive care units, in hospital wards, in emergency departments, and out-of-hospital (by ambulance technicians) for many specific conditions, particularly control of hemorrhage, correction of hypotension, autoperfusion of blood, and immobilization of fractures. The MAST garment has many names, including:

- military antishock trouser[1-2]
- medical antishock trouser[3]
- antishock airpants[4]
- inflatable antishock trousers[5]
- G-suit[6-10]
- antigravity suit[6, 8]
- shock trousers[11]
- pneumatic trousers[12]
- pneumatic suit[13]

In this document the designation of this pneumatic inflatable garment will be the "MAST garment" in order to preclude its confusion with the United States Department of Defense airborne medical program known as MAST (Military Assistance to Safety and Traffic) Medevac.

History

The many names for the MAST garment reflect the several discoveries and re-discoveries of its various functions in providing external counterpressure in medicine and aviation. The first application of a MAST garment to medicine was found in the 1903 report of Dr. George W. Crile Sr., who employed a pressurized pneumatic suit to control the hypotension accompanying blood loss in human patients[13-14]. However, Dr. Crile's pneumatic inflatable garment was not a necessary piece of aviation equipment when Orville Wright made his historic airplane flight at Kitty Hawk, North Carolina, on December 17 of the same year, since the acceleration of that aircraft did not produce sufficient aviator hypotension or blackout through venous pooling to require a pressurized suit.

By the 1930's, aircraft acceleration was sufficient to require an inflatable antigravity suit for aviators. An early model was the 1934 German aviation antigravity suit, which was filled with water. The 1940 Frank G-suit was also filled with water. In 1941, Dr. George W. Crile suggested that the U.S. military use a pneumatic suit to prevent fighter-pilot blackout. The 1944 report of Lambert documented the effectiveness of using a pneumatic inflatable antigravity suit for aviators (*e.g.* a Frank suit filled with air)[15-18].

In 1956, Gardner and Dohn used an aviation antigravity G-suit to control hemorrhage and to correct hypotension resulting from anesthesia. They acknowledged the efforts of Dr. George Crile in this area 50 years previously. In 1958, Gardner, Taylor, and Dohn reported on the use of the antigravity suit in the control of severe postpartum intra-abdominal hemorrhage.[19]

During the 1960's, extensive scientific medical laboratory evaluation was performed on the G-suit for applicability in clinical medicine, using animals[18, 20-24] and normal volunteers[25-26].

In 1969, a "G-suit" was field-tested, out-of-hospital, on severe trauma victims of the Viet Nam war[7]. The suit was applied, at the scene of injury and during helicopter medical evacuation, to 5 U.S. Army and 3 Vietnamese male victims of abdominal, pelvic, perineal, and lower-extremity penetrating hemorrhagic injuries, of a severity

From the Hawaii Medical Association Emergency Medical Services Program (HMA-EMSP) and from Paramedic Parameters. This research project was supported by a grant-in-aid to the HMA-EMS Program from the State of Hawaii Legislature under the State Comprehensive Emergency Medical Services Systems (EMSS) Act Number 148 (enacted June 1, 1978 in the State of Hawaii).

described as "uniformly fatal in our experience despite vigorous resuscitation including massive transfusion." Of the G-suited, 4 survived (50%) and 4 expired pre-, intra-, or post-operatively[7].

In civilian hospitals, during the late 1960's and early 1970's, the anti-gravity suit was used to manage post-operative intra-abdominal bleeding[27], ruptured abdominal aortic aneurysms[28-30], shock[28], a ruptured spleen[28], bleeding after percutaneous renal biopsy[31], bleeding associated with pelvic fractures[32-33], and hypocoagulation hemorrhage[34].

In 1973, Kaplan et al reported on the utilization of the military antishock trouser by fire department paramedics in Miami, Florida, for out-of-hospital civilian emergency medical care[1].

On December 5, 1973, the MAST garment was introduced into Hawaii by Dr. Livingston M.F. Wong during his presentation to the emergency physicians in attendance at the Second Hawaii Emergency Physicians Seminar in Honolulu. Formal classroom instruction, including demonstrations and practice, on MAST garment usage was first provided to the Hawaii Medical Association Emergency Medical Services Program (HMA-EMSP) Emergency Medical Technician (*i.e.* EMT-A level)[35] classroom trainees on November 18, 1976, and EMT-A continuing education sessions on July 14, 1978. Instruction on MAST garment usage was first provided to HMA-EMSP MICT paramedic[36] class trainees on March 29, 1976, and to MICT paramedic continuing education sessions on September 13, 1976. The MAST garment first became a required piece of equipment for Hawaii's civilian emergency ambulance services upon the approval of the State of Hawaii Department of Health Regulations, Chapter 48, on "Ambulances, Ambulance Equipment, Ambulance Services, and Ambulance Personnel," effective date July 1, 1976[37].

In the 75 years between January 1, 1903, and June 30, 1979, more than sixty documents were published on the utilization of the MAST garment principle [1-14, 18-34, 38-66]. More than twenty-five of these report the direct application of the MAST garment to more than 400 [1-2, 6-7, 12-14, 19, 21, 27-34, 44-45, 47-48, 51-52, 55, 57-58, 60-63] (Table 1). The MAST garment has been utilized in attempts to resuscitate patients in more than thirty separate medical conditions (Table 2) including traumatic hemorrhage shock, ruptured abdominal aortic aneurysms and postoperative hemorrhage. The complications and contraindications of MAST garment utilization involve more than forty different areas (Table 3). However, some of these have not been substantiated with published human case reports or suitable prospective scientific evaluation. The paucity of published data regarding the various complications arising from MAST garment use for the various categories of indications precludes an accurate tabulation of reliable MAST suit complication rates, category by category. Also the overall MAST garment complication rate of 12% (Table 4) is not reliable due to the following:

- multiple complications in some patients
- incomplete reporting of complications.

Only very rough mortality percentages can be tabulated (Table 3) for each applicable MAST garment utilization category (with survival being defined as victim discharge alive from the hospital), for the following reasons:

- small category case numbers
- categorization groupings used
- several published reports not providing mortality data.

The overall mortality of 18% in MAST garment utilization requires verification, since the survival/mortality outcomes were not provided in the reports on 48% of the 484 MAST garment patients reviewed. However, the overall MAST garment patient survival of 72% is remarkable, if real, considering the lethality of some of the clinical conditions for which the suit was utilized.

In the context of the actual history of the Medi-

TABLE 1-*Human Case Reports on MAST Garment Utilization*

REFERENCE NUMBER	YEAR REFERENCE PUBLISHED	NUMBER OF CASES	
1	1973	20	
2	1976	66 *	
6	1956	1	
7	1971	8	
12	1977	47 **	
13	1903		
14	1909	1	
19	1958	1	
21	1966	2	
27	1970	1	
28	1970	22	
29	1970	17	
30	1972	17	
31	1972	9	
32	1972	3	
33	1973	2	
34	1973	14	
44	1974	10	
45	1975	1	
47	1975	28	
48	1975	9	
51	1975	4	
52	1976	2	
55	1976	55	
57	1977	(51)*	reported prior
58	1977	69 ** 1	reported prior
60	1977	35	
61	1978	14	
62	1978	25	
63	1979	3	
30 reports		486	cases

TABLE 2-*Medical Conditions in MAST Garment Utilization*

MEDICAL CONDITION	NUMBER OF PATIENTS REPORTED
• Traumatic Hemorrhage (multiple trauma)	123
• Not Given	31
• Shock	98
• Hypotension	69
• Ruptured Abdominal Aortic Aneurysm	37
• Post-operative Hemorrhage: Intra-abdominal (Unspecified)	28
• Acute Myocardial Infarction, (Cardiogenic) Shock	21
• Pelvic Fracture	15
• Hemorrhage after Percutaneous Renal Biopsy	10
• Gastrointestinal Hemorrhage (Unspecified)	9
• Drug Overdose (Type Unspecified)	6
• Post-operative Hemorrhage: Abdominal Aortic Aneurysm Repair	4
• Vaginal Hemorrhage or Hydatidiform Mole	3
• Ruptured Ectopic Pregnancy	3
• Ruptured Varicose Vein(s)	2
• Post-operative Hemorrhage: Partial Nephrectomy	2
• Spontaneous Hepatic Rupture (Gestational)	2
• Third Trimester Bleeding (Unspecified)	1
• Diabetic Ketoacidosis	1
• Anaphylaxis	1
• Emphysema	1
• Ventricular Tachycardia with Pulmonary Embolus	1
• Postural Hypotension	1
• Post Partum Hemorrhage	1
• Post-operative Hemorrhage: Gestational Portal Hypertension	1
• Post-operative Hemorrhage: Pelvic Hematoma after Abdominal Tubal Ligation	1
• Gastric Ulcer	1
• Ruptured Spleen (Solitary Injury)	1
• Perforated Duodenal Ulcer with Peritonitis	1
• Pancreatic Abscess/Fistula Hemorrhage	1
• Post-operative Bleeding: Leukemia and Thrombocytopenia	1
• Orthostatic Hypotension Secondary to Medulla Hemangioblastoma	1
• Post-operative Hemorrhage: Retropubic Prostatectomy	1
• Drowning	1
• Menstrual Bleeding	1
• Dehydration/Hypovolemia	1
• Intra-abdominal Pregnancy (Fetal Death): Hemorrhage:	1
• Post-operative Hemorrhage: Cesarian Section	1
• Post-operative Hemorrhage: Hysterectomy	1
• Acute Renal Failure	1
40 conditions	486 cases

cal Anti-Shock Trouser (MAST) garment, an evaluation was performed on MAST garment utilization by civilian emergency ground ambulance service technicians, in caring for out-of-hospital emergency medical services system patients on the island of Oahu during 1978. The primary intentions of the evaluation were to assess MAST garment utilization and patient outcomes.

Materials and Methods

The Hawaii Medical Association Emergency Medical Services Program (HMA-EMSP) designated this project as "Mast Garment Evaluation Project for Selected EMSS Patients on Oahu between January 1, 1978 and December 31, 1978." This evaluation project was to consist of the following:

1. identification of all utilization of the MAST garment in Oahu emergency medical services system (EMSS) emergency medical patient care by the City and County of Honolulu Department of Health Ambulance Services and their contract emergency ambulance units, between January 1, 1978 and December 31, 1978;
2. evaluation of patient outcomes (*i.e.* survival versus death) for the MAST garment patients specified in the preceding;
3. determination of MAST garment utilization for:
 (a) the general population (*e.g.* number per 100,000 Oahu resident population), and
 (b) the ambulance population (*e.g.* number per 100,000 Oahu City and County of Honolulu Department of Health Ambulance Service and contract emergency ambulance service calls).

Demography

The land mass of the City and County of Honolulu is the Island of Oahu in the State of Hawaii, U.S.A. Oahu contains 592.7 square statute miles[67]. The estimated total resident population of the City and County of Honolulu on July 1, 1978 was 719,600[68]. The public emergency ambulance services on Oahu are provided by:

- the City and County of Honolulu Department of Health Ambulance Services (9 ambulance units), and
- the City and County of Honolulu Department of Health Ambulance Service contracts with private ambulance companies (3 ambulance units).

In 1978, the private ambulance contract for the Aiea precinct was held by the Physicians Ambulance Service, and the private ambulance contract for the Kahuku and Wahiawa precincts was held

TABLE 3-*Complication of MAST Garment Utilization*

COMPLICATION	GENERAL REFERENCES	NUMBER OF SPECIFIC CASES (REF. NO.)
• Area covered by suit cannot be examined	1, 2, 8, 12, 48, 57, 60	
• Restriction of respirations; dyspnea; respiratory distress	1, 2, 8, 11, 28, 47, 49, 57, 58, 60, 61	1(2), "most" (47), 1(57), 1(61)
• Atelectasis; pulmonary edema; pneumonia	19, 47	14(47), 1(19)
• Hypotention or shock or both from rapid suit deflation	2, 6, 8, 9, 12, 28, 30, 32, 34, 44, 48, 49, 55, 60, 63, 65	1(6), 3(9), 4(28), 1(30), 2(34), 1(44), 1(48), 1(55)
• Renal impairment or renal ischemia	2, 7, 57	1(2), 1(57)
• Renal failure	47	3(47) ?
• Decreased urinary output	47	4(47)
• Emesis	1, 2, 8, 28, 57, 60	1(57)
• Blood loss acceleration for areas not covered by suit	2, 7, 57	2(7)
• Instability on walking	19	1(19)
• Defect in suit causing air leakage	34	1(34)
• Skin blisters; skin necrosis	34, 44, 47	1(34), 1(44), 5(47)
• Aortofemoral graft occlusion	47	1(47)
• Cardiac arrest	47, 48	1(47), 1(48)
• Bilateral hemothoraces (from rupture of mediastinal hematoma)	47	1(47)
• Lower extremity functional impairment (*e.g.* peroneal nerve, et al), ischemia	1, 2, 8, 57	
• Acidosis (*e.g.* lactic acidosis) from areas covered by the suit	1, 2, 7, 8, 11, 57, 58, 60, 61	
• Aggravation of pulmonary edema (*i.e.* contraindication)	1, 2, 49, 57 63	
• Aggravation of congestive heart failure (*i.e.* contraindication)	1, 2, 48, 49, 57, 60	
• Urination induced	1, 2, 8, 57, 60	
• Defecation induced	1, 2, 8, 28, 57, 60	
• Jeopardy to pregnancy, fetus (*i.e.* controversial due to newer suit technology availabilities — see reference 66); (*i.e.* contraindication)	2, 65	
• Aggravation of pre-existing intrathoracic hemorrhage (*i.e.* controversial — see cases in references 1, 2, 55, 58)	2, 66	
• Aggravation of tension pneumothorax	65	
• Ischemic skin ulcers	8	
• Neuromuscular injury	11	
• Implanted foreign body worsening of damage (controversial — see reference 66)	11, 66	
• Worsening of abdominal organ evisceration condition	11	
• Skin color of legs not visible	12	
• Feet not included in the garment for certain suit types	12	
• Skin maceration	32	
• Aggravation of cardiogenic shock controversial — see reference 61)	48	
• Peroneal nerve injury	32	
• Aggravation of diaphragmatic hernia	65	
• Aggravation of isolated intracranial hemorrhage (controversial — see reference 65)	48	
• Hyperkalemia	58	
• Aggravation of blunt or penetrating trauma which involves solely the head, neck, chest or upper extremities	49, 66	
• Aggravation of "internal hemorrhage which cannot be controlled by applying direct pressure to the bleeding point"	49	
• Cardiopulmonary insufficiency	66	
• Aggravation of "closed head injuries"	49	
• Aggravation of underlying pulmonary disease	63	
• Aggravation of cerebral edema (*i.e.* contraindication)	63	
• Aggravation of bleeding above the diaphragm (controversial)	63	
• Aggravation of fractured ribs	63	
• Suit punctured	60	
• Suit inadvertantly cut off by emergency personnel	60	57 cases of 486 = 12%

by the Pacific Ambulance Company. The U.S. Department of Defense operated the military emergency ambulance services on the restricted U.S. military installations on Oahu; however, this military ambulance service system was not studied and will not be reported on herein. The 12 civilian emergency ambulance units on Oahu were all staffed with EMT-A[35] or MICT paramedic[36] personnel during 1978. Of the 12 units, 11 were MICT paramedic units during the entirety of the 1978 study period. One (the Waimanalo precinct unit) was an EMT-A unit.

All emergency ambulance units, EMT-A and paramedic, were quipped with a MAST garment throughout 1978 (as required by public health regulation[37]). The City and County of Honolulu Department of Health ambulance units and the Pacific Ambulance Company contract unit used the Clark Medical Anti-Shock Trouser garment (adult, three-piece suit). The Physicians Ambulance Service contract unit used the Jobst Anti-Shock Air-Pants (adult, 3-piece, zipper suit). Therefore, 92% of the ambulance units were equipped with the Clark MAST garment and 8% with the Jobst MAST garment.

General guidelines on MAST garment usage by emergency ambulance technicians provided by the HMA-EMS Program in September, 1976, remained in effect throughout 1978 (Table 4)[69]. All 12 ambulance units used the same statewide ambulance report forms during 1978, with the ambulance technicians documenting MAST garment utilization in the ambulance report form narrative section, MAST suit checkbox, or both. The victim clothed in the MAST garment could have been transported by the emergency ambulance technicians to any one of Oahu's 12 emergency receiving facilities (Table 5), the destination being coded on the ambulance report form. Medical examiner's cases are coded separately as deaths at the scene.

Method

A "MAST Garment Evaluation Project" data form was created in order to collect data on each patient's emergency incident date, age, sex, illness/injury, severity of condition, initial vital signs (VS: blood pressure, pulse rate, respiratory rate), immediate pre-MAST vital signs, MAST (applied) vital signs, post-MAST vital signs, outcome (survived/expired), and autopsy results (if expired). Information was also obtained for the data form, as to the type of ambulance unit (*i.e.* EMT-A versus MICT paramedic) and the cumu-

TABLE 5-*Potential Emergency Receiving Facilities on Oahu in 1978 for Pre-Hospital MAST-Garmented Victims*

Civilian
- Castle Memorial Hospital
- Kahuku Hospital
- Kaiser Foundation Hospital
- Kapiolani-Children's Medical Center
- Kuakini Hospital
- Pearlridge Hospital
- Queen's Medical Center
- St. Francis Hospital
- Straub Clinic & Hospital
- Wahiawa General Hospital
- Waianae Comprehensive Health Center

Military
- U.S. Army Tripler General Hospital

TABLE 4-*Guidelines for MAST Garment Usage*

INDICATIONS
- (1) Severe Intra-Abdominal Hemorrhage
 - ruptured abdominal aortic aneurysms
 - upper GI bleeding
 - lower GI bleeding
 - intra-abdominal organ disruption (blunt trauma, GSW, knife wounds)
- (2) Hemorrhagic Shock Complicating (1) above, and certain other types of Hemorrhagic Shock
- (3) Severe Hemorrhage in areas not covered by the MAST suit, where bleeding can be controlled by direct pressure or pressure dressings, where the MAST suit is used to restore BP
- (4) Severe Retroperitoneal Hemorrhage
- (5) Severe Post-Partum Hemorrhage
- (6) Penetrating Heart Wounds with Cardiac Tamponade (?) *
- (7) Vaginal Hemorrhage, severe (?) *, *excluding pregnancy*
- (8) Direct Pressure for Surface Hemorrhage in areas covered by by the MAST suit
 - abdomen
 - back (lower)
 - perineum
 - buttocks
 - legs
 - esp. spont. rupture of leg varicose veins
- (9) Pelvic Fracture Immobilization
- (10) As Air Splints in Lower Extremity Fractures
- (11) Anaphylactic Shock
- (12) Drug-Induced Hypotension, Temporary, until Antihypotensives or Specific Anti-Drug Rx or IV Fluids or Antibradycardics are Effective
- (13) Neurosurgical Intra-Operative or Post-Operative Hypotension or Air Embolism
- (14) Hypotension from Spinal Anesthesia
- (15) Post-Operative Hypotension from Disseminated Intra-Vascular Coagulation (DIC)? *

CONTRA-INDICATIONS FOR MAST SUIT USE (AT PRESENT)
- (1) CNS Wounds Pre-Hospital (Brain and Spinal Cord), Although Effects for Spinal Cord Trauma Hypotension (*i.e.* Spinal Shock) are Unknown
- (2) Thoracic Wounds where the MAST Suit Promotes Intrathoracic Bleeding to the Extent Hypotension Develops or Remains Unchanged
- (3) Vaginal Bleeding During Pregnancy — Status Uncertain
- (4) Congestive Heart Failure and/or Pulmonary Edema, or the Fluid Overload States
- (5) Probably, Abdominal Section Inflation in the Presence of Renal Failure (Especially if due to Ischemia)
- (6) Possibly, the Cardiogenic Shock of Acute Myocardial Infarction for Certain Types

* QUESTIONABLE INDICATION

lative volume of intravenous normal saline infused pre-hospital and prior to arrival at the receiving hospital emergency department.

For the 12 public emergency ambulance service units on Oahu, there were 28,704 incidents in 1978. All the available ambulance report forms for the City and County of Honolulu Department of Health Ambulance Service Units (the 8 MICT paramedic units and the 1 EMT-A unit) and for the City and County of Honolulu Department of Health contracted ambulance units (the other 3 units, all MICT paramedic) during the period January 1, 1978, through December 31, 1978, were each reviewed by hand by one of us (WN). In addition, Dr. Chester McCall, Jr., Ph.D. of M/M Associates, Los Angeles, developed a computer program which enumerated the Oahu ambulance report form numbers which had the MAST antishock trouser box checked. The third method of detecting the MAST garment cases was by physicians informing us of a 1978 pre-hospital ambulance case wherein the MAST garment was utilized. The ambulance report forms, emergency department charts, and hospital in-patient charts were reviewed on the detected MAST garment cases.

Results

A total of 19 potential instances of pre-hospital civilian emergency ambulance Medical Anti-Shock Trouser (MAST) garment utilizations were detected out of 28,704 ambulance report form incidents for the City and County of Honolulu Department of Health emergency ambulance services and their contracted emergency ambulance services for the January 1, 1978, through December 31, 1978, period. Of these 19, 14 definitely had the MAST garment inflated, 4 definitely did not have the suit inflated, and use could not be ascertained from the records in one case.

There were 14 instances of MAST garment utilization by the City and County of Honolulu Department of Health ambulance services and their contracted ambulance services during calendar year 1978.

Of the 14 cases wherein the MAST garment was actually inflated, 6 survived to be discharged from the medical facility alive, 7 expired, and one had pertinent records unavailable for review. Of the 14 instances of MAST garment utilization by the City and County of Honolulu Department of Health ambulance services and their contracted ambulance services during calendar year 1978, 43% survived the emergency to be discharged alive from the medical facility; 50% expired (either in the emergency department or in the hospital — all from related causes), and 14% were indeterminate, due to record inavailability.

The incidence of MAST garment utilization among the general population of Oahu by the City and County of Honolulu Department of Health Ambulance Services and their contracted ambulance services during calendar year 1978 was 14 cases for 719,600 persons, or 1.95/100,000 population. Oahu's population increase by the tourist/visitor average daily census would provide a MAST garment utilization of 14/799,300 (in 1978), or 1.75/100,000, this representing a corrected incidence.

The incidence of MAST garment utilization among the emergency ambulance incidents of the City and County of Honolulu Department of Health Ambulance Services and their contracted ambulance services during calendar year 1978 was 14 cases for 28,704 incidents, or 48.77/100,000 incidents. (The utilization is actually slightly higher, since cancelled calls, duplicate records, duplicate ambulance responses, etc. are not separated out from the 28,704 incident report forms.)

Discussion and Conclusion

MAST garment utilization by the City and County of Honolulu Department of Health Ambulance Services and their contracted ambulance services was evaluated for calendar year 1978 as to:

- MAST garment utilizations total
- MAST garment utilization patient outcomes (survival versus expiration)
- MAST garment utilization incidence
 - — per 100,000 general resident population
 - — per 100,000 ambulance report form incidents.

Of 19 potential instances of pre-hospital civilian emergency ambulance MAST garment utilizations on Oahu in 1978 detected, there were 14 (74%) proven inflated MAST suit utilizations. Of these 14, 43% survived the emergency to be discharged alive from the medical facility, 50% expired (of related causes), and 14% were indeterminate. The incidence of the MAST garment utilization was 1.95/100,000 general resident population and 48.77/100,000 ambulance incidents (both incidence figures uncorrected.)

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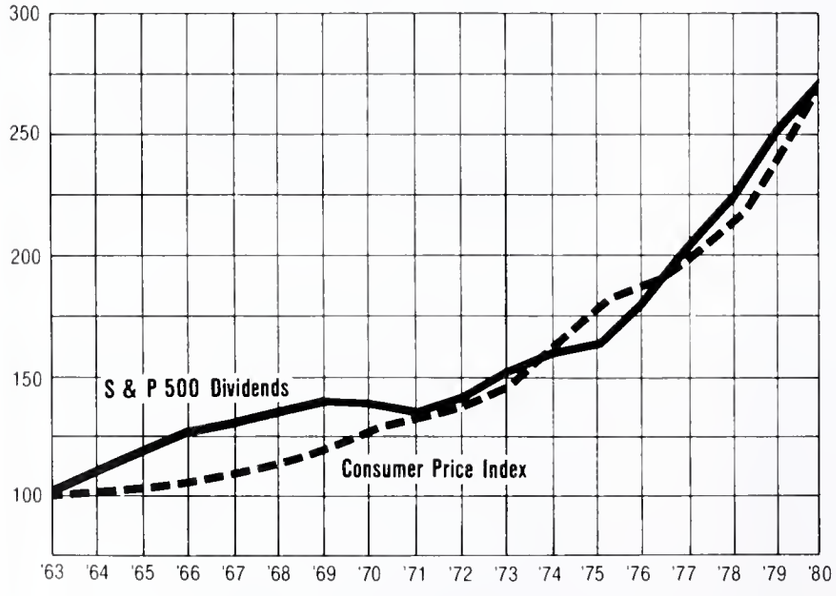
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PUT SOME MORE OF THIS BABY OIL AND IODINE ON MY BACK, WILL YOU, HARRY?
SURE, HAZEL

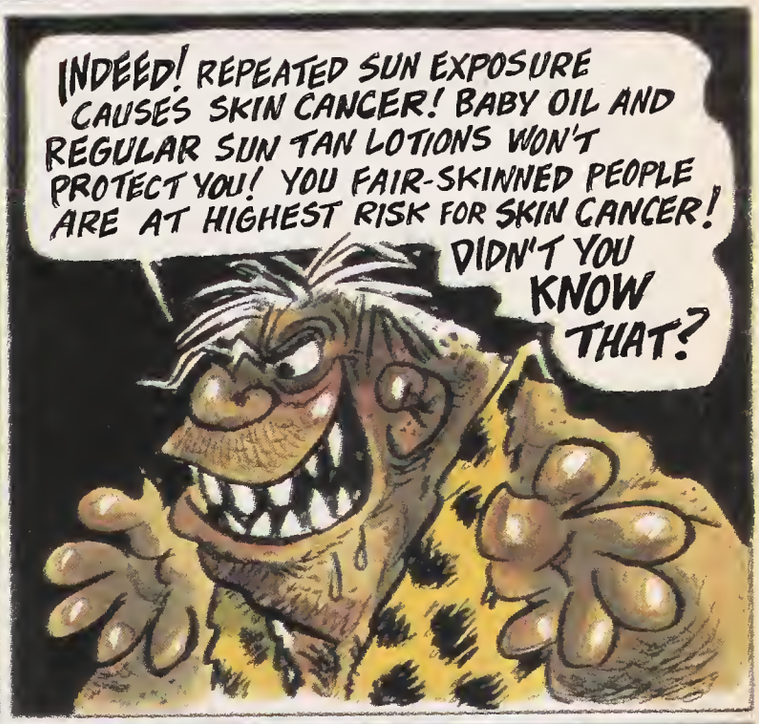

IF YOU PUT ENOUGH JUNK ON, YOU WON'T GET SUNBURNED
THAT OUGHTA DO IT!
MMMMM! FEELS GOOD!
EVERYBODY KNOWS THAT, SMARTY!


ZZZZZZZ
LOOK AT MOM SLEEP!
BOY! WILL THEY EVER BE TAN!
DAD'S GOT A SAND CRAB ON HIM AND HE'S STILL SNORING!

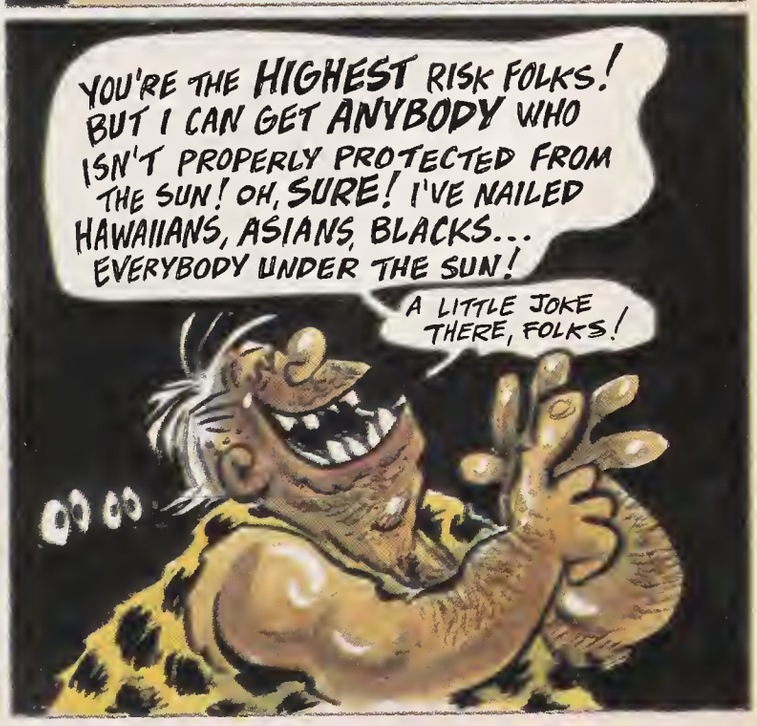

2 HOURS LATER
WOW! I REALLY SLEPT! WHAT TIME IS IT?
ONE O'CLOCK! GOSH, WE ZONKED OUT FOR 2 HOURS!
DAD! YOU LOOK LIKE A LOBSTER!
MOM LOOKS LIKE SASHIMI!
GOSH! WE WERE ONLY AT THE BEACH THREE HOURS!
THAT'S ENOUGH FOR TODAY, DEAR
TOMORROW'S SUNDAY. MAYBE WE CAN COME AGAIN
I HOPE SO! I LOVE BUILDING SAND CASTLES!
I'M A LITTLE BIT SORE!
ME TOO! I DON'T KNOW WHY, WITH ALL THAT GUNK WE PUT ON!
'NIGHT, HAZEL... OOH, THAT SMARTS!
'NIGHT, HARRY... I THINK I BETTER LIE ON MY STOMACH!


...BUT THE HOWZIT'S SLUMBER IS DISTURBED!
I HATE TO AWAKEN YOU TO REALITIES, HOWZITS, I REALLY DO! BUT YOU'VE BEEN VERY FOOLISH! AND YOU'VE RISKED YOUR CHILDREN'S HEALTH AS WELL!


W-W-WHO ARE YOU?
I'M HY RISK! AND YOU, YOU PALE LITTLE CAUCASIANS, ARE MY FAVORITE TARGETS!
Y-Y-YOUR TARGETS?


INDEED! REPEATED SUN EXPOSURE CAUSES SKIN CANCER! BABY OIL AND REGULAR SUN TAN LOTIONS WON'T PROTECT YOU! YOU FAIR-SKINNED PEOPLE ARE AT HIGHEST RISK FOR SKIN CANCER! DIDN'T YOU KNOW THAT?


ARE...ARE WE THE ONLY ONES YOU'RE AFTER?
OH, NO! YOU'RE JUST THE EASIEST! REDHEADS! BLONDES WITH BLUE EYES! AND FRECKLES! YOU BURN EASIEST SO YOU NEED THE MOST PROTECTION! OH BOY! YOU MAKE MY MOUTH WATER!


YOU'RE THE HIGHEST RISK FOLKS! BUT I CAN GET ANYBODY WHO ISN'T PROPERLY PROTECTED FROM THE SUN! OH, SURE! I'VE NAILED HAWAIIANS, ASIANS, BLACKS... EVERYBODY UNDER THE SUN!
A LITTLE JOKE THERE, FOLKS!


SEE, SKIN CANCER DOESN'T CARE WHO IT GETS! YOU'RE A CINCH BECAUSE YOU'RE HAOLES! THE DARKER THE SKIN, THE TOUGHER MY JOB GETS! BUT I'VE GOT A CRACK AT ANYBODY!
A WORD TO THE WISE, HOWZITS! I'M GIVING A COUPLE OF MY PALS YOUR DESCRIPTIONS!
DADDY, YOU WOKE US UP WITH YOUR YELLING! DID YOU HAVE A BAD DREAM?
I'M NOT SURE IT WAS A DREAM... WHERE'S THE DICTIONARY, HAZEL?
HERE IT IS... CANCER. "A DISEASE OF CELLS: OCCURS WHEN CELL DIVISION IS NOT ORDERLY..."
DICTIONARY
"...A MASS OF TISSUE CALLED A TUMOR BUILDS UP. THE TUMOR MAY BE BENIGN OR MALIGNANT. A MALIGNANT TUMOR IS A CANCER."
...AND SO, FINALLY, TO SLEEP!


NEXT MORNING...
I'M GLAD WE DECIDED AGAINST THE BEACH!
ME, TOO. I'VE GOT A FEELING TOO MUCH SUN CAN BE DANGEROUS!
THIS MUCH CAN'T HURT!
I WISH I WERE BUILDING A SAND CASTLE!
WHO'S THAT?
IT'S A MUGGER!
JOG CLUB
NO I'M NOT! I'M REALLY JUST KIND OF A WARNING! I'M SUN KERATOSIS, OR PRE-CANCER!
ARE YOU A FRIEND OF HY RISK?
WE'RE VERY CLOSE! IF YOU KEEP ON EXPOSING YOURSELVES TO THE SUN WITHOUT PROTECTION, I'LL PROBABLY GET YOU SOONER OR LATER!
JUST PROTECT YOURSELVES!!
BUT WHEN?


NOON
WHEW! IT'S GOOD TO BE HOME!
GEE, LAST NIGHT HY RISK AND THIS MORNING THAT PRE-CANCER MUGGER!
WHO'S NEXT?
YOU CALLED?
JOG CLUB
I'M BASAL CELL CARCINOMA, BUT YOU CAN CALL ME BASIL!
YOU REMIND ME OF A NICE LITTLE BOY I USED TO BABY-SIT!
WHAT IS THIS, ANYHOW? A MONSTER MOVIE? WHO THE HECK ARE YOU?
OKAY! OKAY! WHAT'S A BASAL CELL CARCINOMA?
ACTUALLY, CONSIDERING I'M A SKIN CANCER, I'M NOT ALL THAT BAD! I'M THE MOST COMMON AND EASILY CURED IF FOUND AND TREATED EARLY!
I DON'T THINK THAT'S THE ONE I USED TO BABY-SIT!
JOG CLUB
YOU CAN RECOGNIZE ME BECAUSE I'M SHINY---SEE?--- I RARELY SPREAD OR KILL. IN FACT, WITH EARLY DETECTION, SIMPLE TREATMENT GETS RID OF ME IN 97% OF THE CASES!


BUT YOU PEOPLE ARE NUTS! OUT IN THE NOONDAY SUN?! I THOUGHT EVERYBODY KNEW 10 A.M. TO 2 P.M. WERE THE MOST DANGEROUS HOURS! SAY HELLO TO MUGGSY FOR ME!
MUGGSY WHO?
MUGGSY ME, YOUSE GUYS! I'M DA KILLER, ONE OF DA FASTEST CANCERS IN DA WEST! MUGGSY MELANOMA!!
WHAT DO YOU WANT WITH US?
(CHUCKLE) JUST YOUR LIVES, DAT'S ALL! I BEEN DOUBLIN' EVERY 10 YEARS! I PUT 13,600 NOTCHES IN MY BELT IN '79! I ONLY KILLED ABOUT 4,000 OF 'EM, BUT MY PROSPECTS LOOK BETTER IF YOU DUMMIES DON'T START FINDIN' ME EARLY AN' GETTIN' A DOCTOR TO CHECK ME!
CH-CH-CHECK WHAT ?
CHECK ANY CHANGES IN MOLES AN' WARTS OR SORES THAT DON'T HEAL! IF YOU DON'T...


PSSST, HARRY! HE'S BACK!
WHO'S BACK?
MUGGSY MELANOMA! AND HE'S BROUGHT A FRIEND! AND HIS DOG!
AAAAHHHRRGH!
UH... HOW DO YOU DO, MR. VILE
YEH, IT'S ME. I BRUNG A PAL. SAY HELLO TO ULTRA VILE AN' HIS MEAN DOG SPOT!
UH... ARF, SPOT!
KNOW WHY HE'S CALLED ULTRA VILE?
I HATE TO ASK. WHY?
BECAUSE MY REAL NAME IS ULTRAVIOLET RAY! YEARS WHEN THERE'S LOTS OF SOLAR ACTIVITY ARE GREAT FOR ME AND MY DOG SUNSPOT!
...AN' DA WORST FOR HUMANS, RIGHT, ULTRA?
RIGHT, MUGGSY, BECAUSE I'M A B-BAND OF ULTRAVIOLET RAYS AND I THRIVE ON ELECTROMAGNETIC ACTIVITY ON THE SUN. WHEN CONDITIONS ARE PERFECT, SUNSPOTS GO BANANAS TOO, AND WE MAY BE CAUSING MORE SKIN CANCERS THAN EVER!
AH, YES... BUT WE CAN WAIT!
IT TAKES 2 OR 3 YEARS FOR 'EM TO SHOW UP, THOUGH!

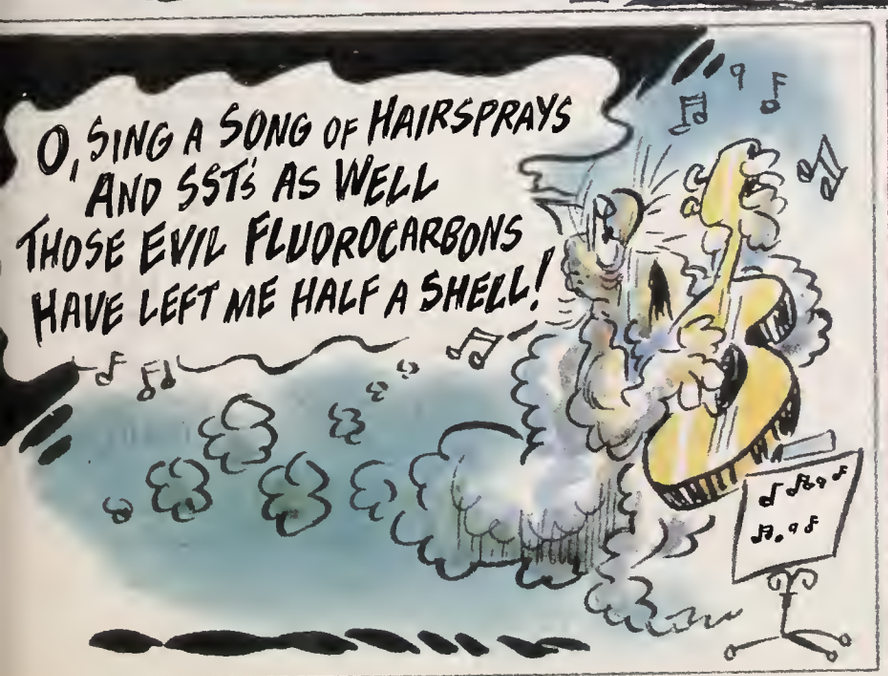

YOU'RE DRESSED IN RED, WHITE AND BLUE!
MOST PEOPLE DON'T EVEN RECOGNIZE ME UNTIL I TAKE OFF MY SHIRT!
YEH, DAT'S MY TRADEMARK! I GOT A REAL COLORFUL PERSONALITY!
YOU SURE DO! WOW! IRREGULARLY SHAPED... KINDA NOTCHED ALL OVER... BUMPY... BROWN... BLACK... RED... WHITE... BLUE...
YUK!
...AN' WHEN I GET REALLY MEAN, I GET BIGGER AN' DARKER AN' MAY EVEN BLEED A LITTLE!
YOU'RE A REAL KILLER, MUGGSY!
YUK!
SOMETIMES DOSE FINKY FAMILY DOCTORS OR DENTISTS SPOT ME EARLY! DEN, IF I GET TREATED BY A PHYSICIAN, IT'S...
...CURTAINS FOR YOU, HUH, MUGGSY?
YEH! MOSTA DA TIME, I'M FINISHED!
CLKK


MEANWHILE...
WHAT'LL WE DO?
IT LOOKS PRETTY GRIM!
THOSE AWFUL CANCERS ARE EVERYWHERE UNDER THE SUN!
WON'T SOMEBODY SAVE US?
I'LL HELP! I'M PABA MAN, THE WORLD'S GREATEST SKIN CANCER FIGHTER! AND THIS IS MY MIGHTY SPIFFY SQUAD!
POOF
ZAP
SPF
PABA
WHAT'S A PABA MAN?
AND WHAT'S A SPIFFY SQUAD?
PABA STANDS FOR PARA AMINO BENZOIC ACID! IT BLOCKS HARMFUL SUN RAYS BETTER THAN ANYTHING ELSE!
WE STAND FOR SUN PROTECTIVE FACTOR!
IT MEANS THE AMOUNT OF SUN PROTECTION A PARTICULAR SUN SCREEN WILL GIVE YOU!
FOR INSTANCE, A SUN PROTECTIVE FACTOR OR SPF OF 15-19 EQUALS A COMPLETE SUNBLOCK! AN SPF OF 8 ALLOWS TANNING, BUT PREVENTS SKIN CANCER!
IN OTHER WORDS, THE HIGHER THE SPF, THE BETTER THE PROTECTION!
WHAT'S THAT MEAN?

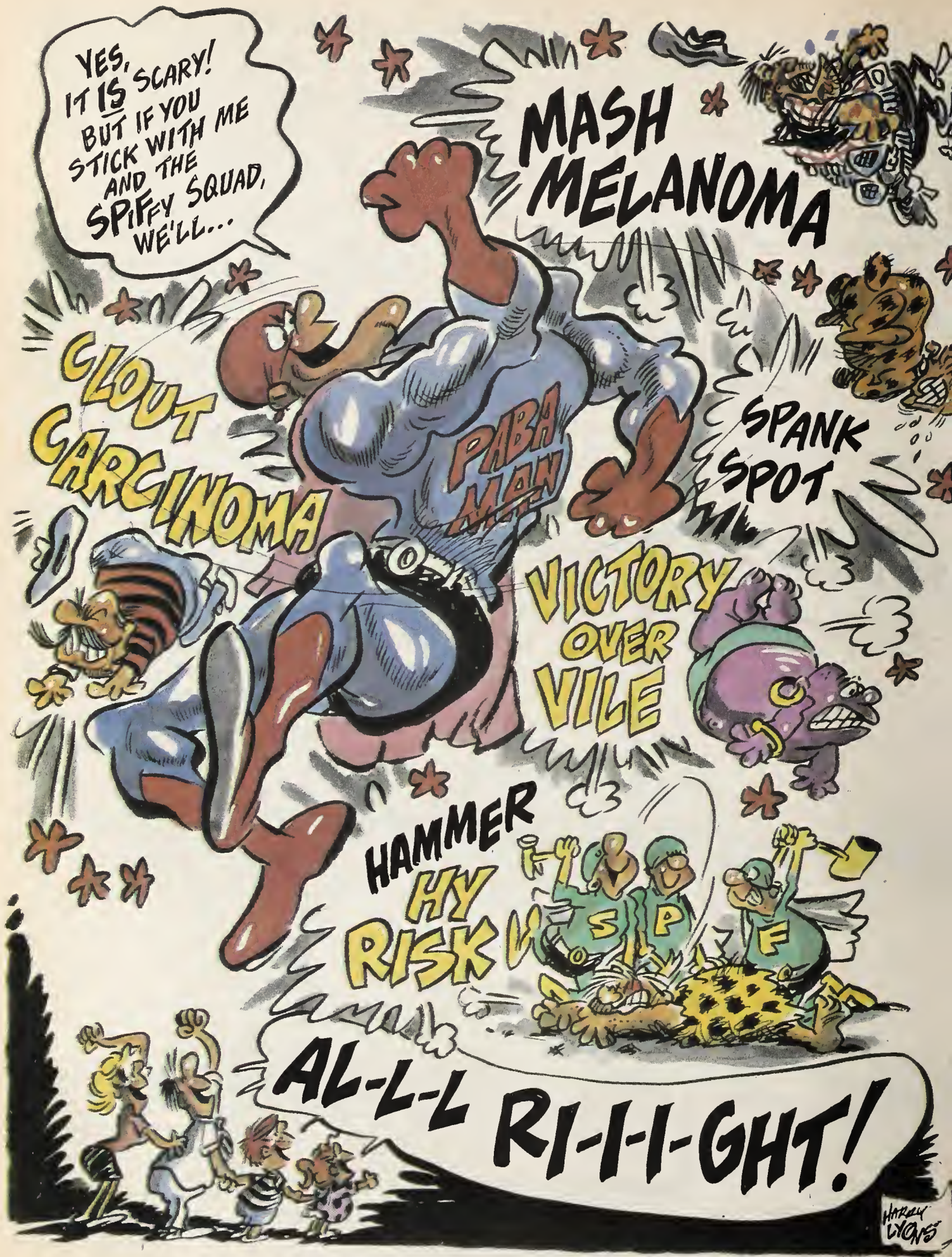

AND LOWER THAN AN 8?
WE DON'T RECOMMEND IT, BECAUSE...
SPFs LOWER THAN 8 DON'T PROTECT ENOUGH...
AGAINST ULTRA VILE!
SPF

LOOK ON THE LABEL, HONEY! MOST GOOD SUN PREPARATIONS HAVE IT THERE!
AND ALWAYS USE ONE WITH PABA OR ITS RELATIVES, PABA ESTERS!
HOW DO WE KNOW WHAT THE SPF IS IN OUR SUNTAN LOTION?
IF IT DOESN'T HAVE AN SPF NUMBER, BEWARE!
S
P
F

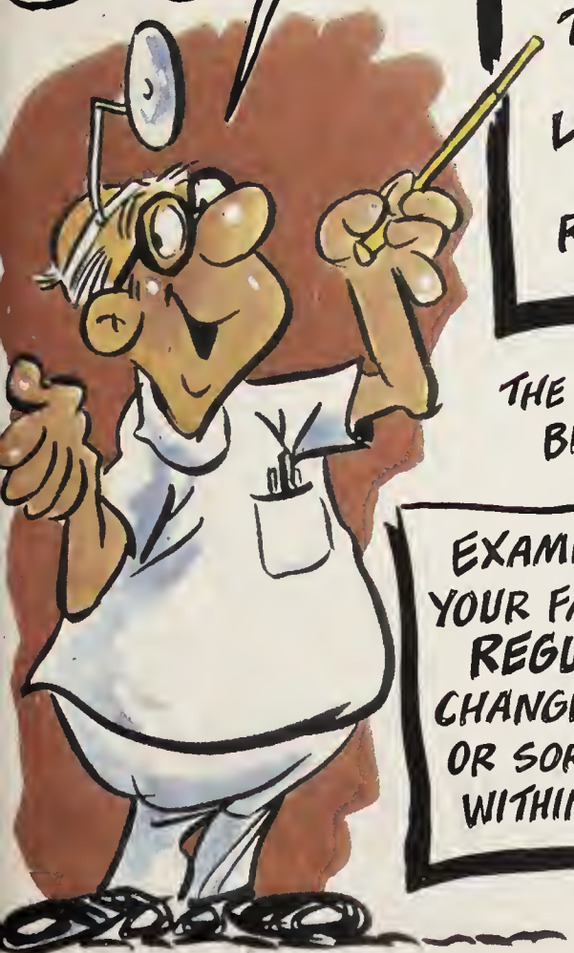
HEY, PABA MAN! WHO'S THIS GUY FLOATING IN?
OH, THAT'S THE WIZARD of OZONE, POOR DEVIL... USED TO BE A TERRIFIC SKIN CANCER FIGHTER, BUT HE'S OVER THE HILL, POOR GUY!


O, SING A SONG OF HAIRSPRAYS AND SSTs AS WELL THOSE EVIL FLUOROCARBONS HAVE LEFT ME HALF A SHELL!


THE WIZARD IS THE OZONE LAYER THAT CIRCLES AND PROTECTS THE WORLD! HE'S ONLY ABOUT HALF AS THICK AS HE WAS 15 YEARS AGO!
REFRIGERANTS, HAIR SPRAYS, SHAVE CREAMS, INSECT REPELLANTS ... ALL THAT JUNK!
WHY?
WHAT'S THAT MEAN?
THAT'S SCARY!


YES, IT IS SCARY! BUT IF YOU STICK WITH ME AND THE SPIFFY SQUAD, WE'LL...
MASH MELANOMA
CLOUT CARCINOMA
PABA MAN
SPANK SPOT
VICTORY OVER VILE
HAMMER HY RISK
S P O F
AL-L-L RI-I-I-GHT!
HARRY LYONS

I'M DOC BLOCK! THEY CALL ME THAT BECAUSE I TEACH FOLKS LIKE YOU HOW TO BLOCK THE SUN'S RAYS WHICH CAN HARM YOU AND CAUSE SKIN CANCER. JUST REMEMBER THESE IMPORTANT TIPS: THEY CAN SAVE YOUR LIFE!



EARLY DETECTION OF ANY TYPE OF CANCER IS IMPORTANT!

REMIND FAMILY DOCTORS & DENTISTS TO CHECK FOR WARNING SIGNS

REMEMBER, SKIN CANCER IS DIRECTLY RELATED TO SUN EXPOSURE, SO...

LOOK FOR THE SPF (SUN PROTECTIVE FACTOR) ON EVERY SUN PREPARATION PRODUCT. A NUMBER OF 15-19 WILL GIVE YOU TOTAL SUNBLOCK, AN 8 WILL LET YOU TAN, BUT PREVENT SKIN CANCER. LESS THAN AN 8 IS NOT RECOMMENDED!

USE AN ADEQUATE SUN SCREEN EVERY DAY! IT'S A HABIT THAT CAN PREVENT SKIN CANCER!

THE CAUSE OF MELANOMA IS NOT KNOWN, BUT IT APPEARS ON THE SKIN, SO...

EXAMINE YOUR SKIN AND YOUR FAMILY'S SKIN ON A REGULAR BASIS, FOR: CHANGES IN MOLES OR WARTS, OR SORES THAT DON'T HEAL WITHIN A 2-WEEK PERIOD.

EYBSOYB*

TIE YOUR SKIN EXAMINATION TO A CERTAIN DAY!

*EXAMINE YOUR BIRTHDAY SUIT ON YOUR BIRTHDAY!


WE'RE PROTECTED!
ARE YOU?
SPF 8
SPF 15
SPF 15
SPF 15
HARRY LYONS

Can you answer these questions about *skin cancer* and *melanoma*?

1. Write 'SC' next to the words that describe **skin cancer.**
 Write 'M' next to the words that describe **melanoma.**
 Write 'SC/M' if the words are true for **skin cancer** and **melanoma.**

 a) ____ rarely spreads or kills if treated early (hint: see page 6)
 b) ____ is caused by exposure to the sun's rays without protection (hint: see pages 5 & 13)
 c) ____ more common than the other (hint: see page 6)
 d) ____ can be signaled by a change in a mole (hint: see pages 7 & 13)
 e) ____ should be checked by a physician at the first sign (hint: see page 7)

2. A **high risk factor** is a condition that means a person has a greater chance of getting a disease. (hint: see page 3)

 ____ True ____ False

3. Check any of these that are high risk factors for skin cancer or melanoma: (hint: see pages 3 & 7)

 ____ green teeth
 ____ blonde hair
 ____ spending a lot of time in the sun
 ____ moles
 ____ red eyes
 ____ warts
 ____ fair skin
 ____ blue eyes
 ____ freckles
 ____ purple elbows
 ____ red hair
 ____ smoking cigarettes

4. Only Haoles are at risk for skin cancer and melanoma. (hint: see page 3)

 ____ True ____ False

5. What is PABA? (hint: see pages 10 & 11)

 a) a type of surfboard
 b) a chemical which protects against skin cancer
 c) baby food

6. A sun protective factor (SPF) of '6' on a bottle of sunscreen lotion indicates that the lotion will provide adequate protection for most people who are at high risk for skin cancer. (hint: see pages 10 & 11)

 ____ True ____ False

7. Which are the most dangerous hours to be out in the sun unprotected?

 a) 6 AM - 9 AM
 b) 10 AM - 2 PM
 c) 2 PM - 5 PM
 d) 3 PM - 6 PM

8. Everyone should examine his or her skin on a regular basis for: (hint: see pages 7 & 13)

 a) ____ change in moles
 b) ____ change in warts
 c) ____ sores that don't heal in two weeks
 d) ____ all of the above

9. If a change is discovered in a mole or wart, or, if a sore doesn't heal within two weeks, you should put coconut oil on it and forget it. (hint: see pages 9 & 13)

 ____ True ____ False

10. You've learned from the Howzit family's experience that it is important to use a sunscreen product with a sun protective factor (SPF) appropriate for your skin color.
 What SPF do you think is appropriate for you? ____ SPF
 (hint: see pages 3 & 11)

Turn the page to find the correct answers.

Answers:

1. a) SC/M **Skin cancer** rarely spreads or kills **if** found and treated early. If **skin cancer** is ignored, it can kill. **Skin cancer** usually does not move to other parts of the body but **melanoma** does if it is not removed very early.
 b) SC/M Most **skin cancer** is caused by exposure to the sun's ultra-violet rays. One cause of **melanoma** seems to be exposure to the sun; but some **melanomas** occur on areas of the body that are not exposed, so there are probably other causes of **melanoma.**
 c) SC Many more **skin cancers** occur than **melanomas** but **melanoma** is more deadly.
 d) M Some danger signs of **melanoma** are changes in warts or moles and sores that don't heal in two weeks.
 e) SC/M **Cancer** should **never** be ignored. A physician should be asked to check the first signs of **skin cancer** or **melanoma.**
2. TRUE
3. The high risk factors that the Howzit family learned about are:
 -- spending a lot of time in the sun (especially from 10 AM to 2 PM)
 -- having moles
 -- being Caucasian, especially with blonde or red hair, blue eyes and freckles
 Three other risk factors for skin cancer/melanoma are:
 -- having had other types of cancer
 -- having relatives who have had skin cancer or melanoma
 -- living close to the equator
4. FALSE. Very fair-skinned Haoles are at highest risk for skin cancer and melanoma but non-Caucasians are also at a risk, although at lower risk than Caucasians.
5. (b) PABA (para amino benzoic acid) and PABA esters, when applied to the skin, protect it against the harmful rays of the sun.
6. FALSE. An SPF of '8' is the minimum which will allow tanning but prevent skin cancer. People with very fair skin should use a sunscreen with an SPF of '15' or even '19' everyday, since many sunscreen products have an increased effect with regular use.
7. (d) 10 AM to 2 PM are the hours during which the sun's ultra-violet rays are most direct and intense and, therefore, most dangerous.
8. (d) all of the above
9. FALSE. It is important to see a physician at the very first sign of skin cancer or melanoma. Both types of cancer have a much better chance of being cured when found and treated early.
10.

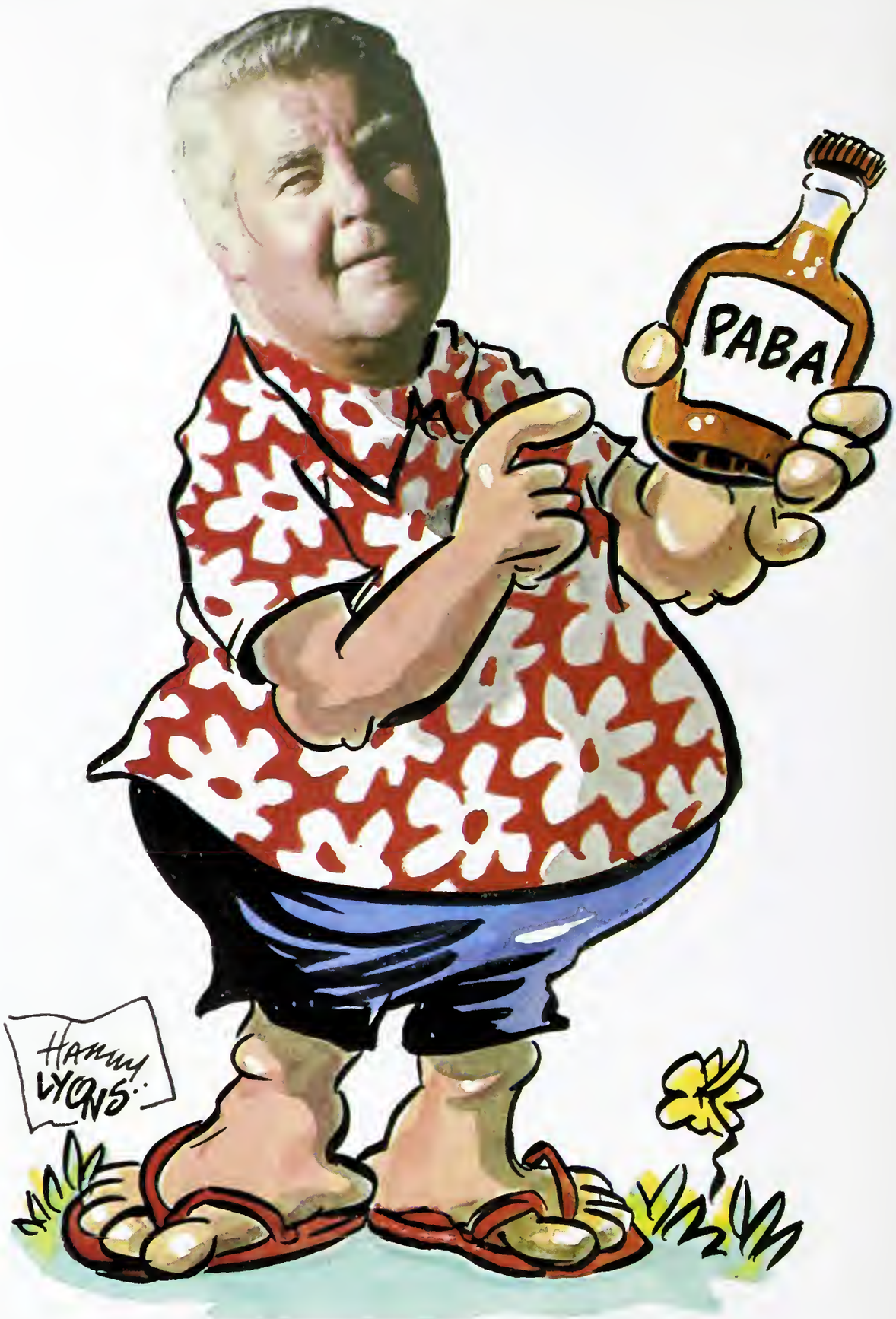
If your skin color is:	you should use a sunscreen product with an:
very light	SPF 15 or above
medium	SPF 10
dark	SPF 8

For protection against skin cancer, sunscreen products with sun protective factors (SPF) of less than '8' are not recommended. Determine how long it takes you to get a slight pinkness of skin if you go out in the sun with no protection. Multiply that time by an SPF number, and you will find the amount of time you can spend in the sun without turning pink. The higher the SPF number, the more time you can spend in the sun without burning. For example, if it takes you 10 minutes to turn pink and you use a sunscreen with an SPF of 8, you will have 80 minutes of protection.

# of minutes needed to turn pink	x SPF =	# of minutes of protection
10	x 8 =	80

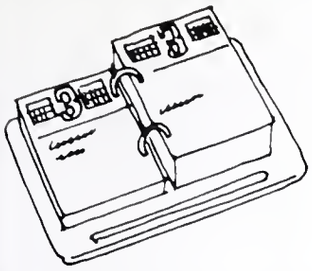


Call Collect From Neighbor Islands
IT'S FREE!



Harry Lyons is one of Hawaii's best-known cartoonists and writers. In 1979, after 20 years as a daily editorial cartoonist and columnist for the Honolulu Advertiser, he moved to the Big Island where he currently free lances. He also writes and illustrates a column for West Hawaii Today, a Kona newspaper.

Lyons was named Hawaii's 1977 "Man of the Year" in the field of art and has won numerous national awards including four prizes in the Grenville Clark "World Peace Through World Law" editorial cartoon competition and two Valley Forge Freedoms awards.



Continuing Medical Education

CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G.N. Wilcox Memorial Hospital, First Thursday, 12:45 p.m. and Fourth Tues. 12:30 p.m. w/Maui Mem. Hsp. Held on Oahu at Am. Cancer Society main conf. room, 200 N. Vineyard, Honolulu.

John A. Burns School of Medicine

1. Dept. of Medicine
 - A. Case Conferences, Second and Fourth Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 - B. Grand Rounds, First and Third Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 - C. Endocrinology Grand Rounds, Third Wednesdays, 5:30-6:30 p.m., Queens University Tower, Room 506.
 - D. Hematology Grand Rounds, Second and Fourth Mondays, 12:30-1:30 p.m., Queens University Tower, Room 721.
 - E. Cardiology Grand Rounds, First and Third Tuesdays, 5:30-6:30 p.m., Queens University Tower, Room 508.
 - F. Infectious Disease Grand Rounds, Second and Fourth Tuesdays, 5:00-6:00 p.m., Queens Nalani I Conference Room.
 - G. Dermatology Grand Rounds, Second Wednesday, 7:30-8:30 a.m. Queens, Queen Emma Clinic.
 - H. Pulmonary Grand Rounds, Second and Fourth Thursdays, 4:30-5:30 p.m., Queens Kamehameha Auditorium.
2. Division of Nuclear Medicine
 - A. Technical aspects of Nuclear Medicine, Second Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506, 1½ credits.
 - B. Rounds, Fourth Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506.
3. Dept. of Obstetrics and Gynecology
 - A. Grand Rounds, Wednesday 7:30-8:30 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
4. Division of Orthopaedics
 - A. Fracture Conference, Tuesdays, 5:00-6:00 p.m., Queens University Tower, Room 618.
 - B. Shriners Hospital Conference, Tuesdays, 7:15-9:15 a.m., Shriners Hospital.
5. Dept. of Pediatrics
 - A. Grand Rounds, Thursdays 8:00-9:00 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 - B. Pediatric Conference, Mondays 12:45-1:45 p.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 - C. Pediatric Infectious Disease Conference, Thursdays, 12:30-1:30 p.m., Kapiolani-Children's Medical Center, Third Floor Conference Room.
 - D. Neonatal Ground Rounds, Fridays, 8-9:00 a.m., Kapiolani-Children's Medical Center, Administrative Conference Room.
6. Dept. of Psychiatry
 - A. Grand Rounds, Fridays 8:00-9:30 a.m., Queens University Tower, Room 618.
7. Dept. of Surgery
 - A. Grand Rounds, First, Second and Third Saturdays, 7:30-9:00 a.m., rotating hospitals.
 - B. Statistical M and M, last Saturday, 7:30-9:00 a.m., rotating hospitals.
 - C. Journal Club, First and Third Tuesdays, 6:00-8:00 p.m., Queens University Tower, Room 620.
 - D. Medical-Surgical G.I. Rounds, Second Tuesday, 7:00-8:00 a.m., Queens University Tower, Room 506.
8. Dept. of Family Practice
 - Conf., Wednesdays, 8-9:00 a.m. Kaiser 4th Floor Conf. Room.
 - B. Conf., Thursdays, 12-1:00 p.m. Kaiser 4th Floor Conf. Room.
9. Dept. of Physiology
 - A. Dept. Conf., Wednesday, 4:30-5:30 p.m. BioMed T-210.
10. University of Hawaii, John A. Burns School of Medicine Grand Rounds, Third Thursday, 4:30-6:00 p.m., Queen's University Tower, Room 618 or BioMed Building.
11. HI Oncology Group, one Monday a mnth., 12:30-1:30 p.m., The Cancer Center, 1236 Lauhala St., 4th Floor Conference Room.

Federation of Emergency Medicine-Maui

1. Cardiology for the Emergency Physician
 Every Monday, 9-10:00 a.m.-Maui Memorial Hsp. Conf. Rm#1. (For spec. topics or further info. contact: Federation Office (808) 244-7629, or Dr. C.T. Michell, (808) 244-9056.
2. Journal Club in Emerg. Medicine. 2 hrs. Cat. 1. MMH Conf. Rm. #1. 9 a.m.-11 a.m.
 9/21/81 Annals in Em Med, 5/81; Abstracts in EM 6/81 - S. Burkle
 10/19/81 Annals in Em Med, 6/81; Abstracts in EM 7/81 - P. McCallum
 11/23/81 Annals in Em Med, 7/81; Abstracts in EM 8/81 - J. Mills
 12/221/81 Annals in Em Med, 8/81; Abstracts in EM, 9/81 - C. Mitchell

Hawaii Thoracic Society

1. Pulmonary Med., Clinical case presentations & current research in pul. med. with U of H Sinclair Chest Club. Third or Fourth Wed., ea month, 7:30 p.m.-9:30 p.m. For further info contact: Rosemary Respicio, B.S.N. at (808) 537-5966.

Hickam Clinic

1. Clinic Correlation Conference, First Thursday, 11:00 a.m.
2. Didactic—our staff, Second Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, Third Thursday, 11:00 a.m.
4. Radiology Conference, Fourth Thursday, 11:00 a.m. (Contact Aurora Macapinlac, M.D., M.C., 449-5770)

Hilo Hospital

1. Orthopedic Conference, First Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7-8 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, Second Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, Third Friday, 12:30-1:30 p.m.
5. C.P.C., Second Friday, 12:30-1:30 p.m.
6. Visiting Professor's Program

Kaiser Hospital

1. Medicine Grnd. Rnds. Every Tues. 8 a.m. Pac. Aud. 1 hr. Cat. 1.
2. Tumor Board—Every Tues. 12:00 noon. Pac. Aud. 1 hr. Cat. 1.
3. OB/Ped. Perinatal Mortality Conf. Last Tues. ea. mnth. 8:00 a.m. 1 hr. Cat. 1.
4. Surg. Grnd. Rnds. Every Fri. 8:00 a.m. Pac. Aud. 1 hr. Cat. 1.

5. Sat. Morning Educational Conf. Every Sat. 7:30 a.m. Pac. Aud. 1 hr. Cat. 1.
(Contact CME Dept.-Kaiser for further information)

Kapiolani-Children's Medical Center

1. Pediatric Grnd. Rnds. Every Thursday, 8-9:00 a.m. Aud.
2. Pediatric Conf. Mondays, 12:45-1:45 p.m. 2nd Floor Aud.
3. Neonatal Grnd. Rnds., Fri. 8-9:00 a.m., Conf. Rm. B.
4. Pediatric Infectious Disease Conf., Thursdays, 12:30-1:30 p.m. 3rd Floor Conf. Rm.
5. Ob-Gyn Conf. Tues. 1-2:00 p.m. Aud.
 First—Didactic Presentation
 Second—Perinatal-Neonatal Topics
 Third—Obstetrics Topics
 Fourth—Gyn Topics
6. Tumor Brd.—Oncology Conf. First and Third Fri. 1-2:00 p.m. Aud.

Kuakini Medical Center

1. Department of Ophthalmology Mtg., First Tuesday, 12:30-1:30 p.m.
2. Department of Medicine Mtg. (Statistical), Fourth Tuesday, 1:00-2:00 p.m.
3. G.I. Conference, First Tuesday, 8:00-9:00 a.m.
4. Nephrology Conference, First Wednesday, 8:00-9:00 a.m.
5. Oncology Conference, every Thursday, 7:30-8:30 a.m.
6. Pulmonary Conference, First Thursday, 1:00-2:00 p.m.
7. Surgical Conference, First & Second Friday, 12:45-1:45 p.m.
8. Surgical M & M Conference, Fourth Friday, 12:45-1:45 p.m.
9. Department of Medicine Evening Mtg., Second Tuesday, 5:30-7:00 p.m.
10. Visiting Professor Program
 (for further info contact CME Dept. 547-9226 as these programs may be subject to change.)

Maui Memorial Hospital

1. Thurs. Conf. 7-8:00 a.m. Staff Dining Rm.
 1st—Dept. of Medicine
 2nd—Dept. of Surgery
 3rd—Dept. of OB/GYN
 4th—Dept. of Pediatrics
 5th—Elective
2. Tumor Brd. every Mon. 12:15-1:15 p.m.—Tumor Conf. Telephone Task Force—Third Tues. 12:15-1:15 p.m.
3. Dept. of Emergency Med., Third Mon., 7-8:00 a.m.
4. Diagnostic Radiology—Fourth Tues., 12-1:00 p.m.
5. SFH-UH Hematology Conf., Third Thursday, 12:30 p.m. Sullivan-4 Classroom.
6. SFH-UH Surgical Grand Rounds, First, Second, & Third Fridays, 7:30 a.m., Sullivan-4 Classroom.
7. Visiting Professor Programs (for further info call CME office at St. Francis).

The Queen's Medical Center

1. ENT Conferences, First and Second Fridays, 7:30 a.m., Small Dining Room.
2. Medical Conferences, Every Friday, 8:00 a.m., Kam Auditorium.
3. Ob/Gyn Conferences, Second and Fourth Mondays, 1:00 p.m., Kam Auditorium.
4. Ophthalmology Conference, Fourth Tuesday, 5:00 p.m., Queen Emma Eye Clinic.
5. Orthopaedic Conferences, Every Wednesday, 7:00 a.m., Kam Auditorium.
6. Pathology Conferences, Every Wednesday, 7:30 a.m., Surgical Conference Room.
7. Pediatric Grand Rounds, Fourth Thursday, 12:30 p.m., Nalani 1 Conference Room.
8. Surgical Trauma Conference, Second Tuesday, 4:30 p.m., Kam Auditorium.
9. Basic Science Lectures, Every Wednesday, 7:15 a.m., Queen's University Tower, Room 618.

St. Francis Hospital

1. SFH-UH Tumor Conf., Every Monday, 7:30 a.m. Sullivan-4 Classroom.
2. SFH-UH Nephrology Conf., First Monday, 1:00 p.m. Sullivan-4 Classroom.
3. SFH-UH Endocrine Conf., Last Monday, 12:30 p.m. Sullivan-4 Classroom.
4. EENT Meeting, First Tuesday, 7:00 a.m., Sullivan-4 Classroom.
5. SFH-UH Hematology Conf., Third Thursday, 12:30 p.m. Sullivan-4 Classroom.
6. SFH-UH Surgical Grand Rounds, First, Second, & Third Fridays, 7:30 a.m., Sullivan-4 Classroom.
7. Visiting Professor Programs (for further info call CME office at St. Francis).

Straub Clinic & Hospital

1. Straub Professional Seminar meets the Second Tuesday of each month, from 5:00-6:30 p.m. in the Credit Union Meeting Room (2nd Floor, Credit Union Bldg.).
2. Surgical Mortality and Morbidity Conference meets every Fourth Thursday of each month, from 7:00-8:00 a.m. in the Doctors' Dining Room.
3. Cardiac Surgery Conference meets the Third Tuesday of each month, from 4:30-5:30 p.m. in the Doctors' Dining room.
4. Department of Anesthesiology meets the Second Tuesday of each month from 7:00-8:00 p.m. in the Doctors' Dining Room.
5. Community Peripheral Vascular Conference meets the Forth Thursday of each month from 5:00-6:30 p.m. in the Doctors' Dining Room.
6. Visiting Professor Program meets monthly from 7:00-8:00 a.m. in the Doctors' Dining Room.
7. Urology Inservice meets every other month on the Third Friday from 8:00-9:00 a.m. in the Doctors' Dining Room.
8. Neuropathology Clinical Correlation Conference meets the Third Thurday of each month from 7:30-8:30 a.m. in the Straub Morgue.
9. OB-GYN Pathology meets every Fourth Monday of each month from 12:30-1:30 p.m. in the Administration Conference Room (ACR).
10. Urologic Pathology meets every First Monday of each month from 8:00-9:00 a.m. in the Doctors' Dining Room.
11. Friday Noon Conference meets every Friday of each month from 12:30-1:30 p.m. in the Doctors' Dining Room.

*Note: All conferences are subject to change. Monthly calendar will be available upon request.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. Department of General Practice Meeting—Last Wednesday
2. General Medical Staff Meeting—Second Tuesday
3. Clinical Review Meeting—Alternate Mondays at noon
4. Tumor Conference—First Thursday

Miscellaneous

HMA Maternal and Perinatal Mortality Study Cmte. First Monday ea. month-5:30 p.m. 320 Ward Ave., S 200. Cat. 1 on hr. for hr. basis.

SPECIAL EVENTS

Aug. 26, Sept 7, 1981	Third Ann. Radiology for Nonradiologists. San Diego Rad. Res. & Educ Found, Box 2305, LaJolla, CA. 92038; cospons: Am Col of Radiology. Held: Kauai Surf Resort Htl, Kauai. 35 hrs. Cat. I.
Aug 29-Sept 4, 1981	Concepts in Infertility-1981, Royal Lahaina, Maui, Stanley Friedman, The Edward Tyler Medical Clinic, 921 Westwood Blvd., LA 90024.
Oct. 7-9,1981	"Current Neurology." Straub Clinic & Hsp. Held: Honolulu Art Academy Aud., 900 S. Beretania Honolulu. Contact: Off. of Med. Admins., Straub,. 888 So. King St. Honolulu, 96813; (808) 523-2311.
Oct. 10, 18, 1981	Sixth Annual International Body Imaging Conference. West Park Hosp., 22141 Roscoe Blvd., Canoga Park, CA 91304. Held: Hyatt Regency Htl, Maui.
Oct 12, 16, 1981	Oncology Board Review, Princess Kaiulani, ACP, Dr. Thomas Hall, Cancer Center of Hawaii, 1236 Lauhala, Honolulu 96813.
Oct 12, 16, 1981	AMA Regional & Scientific Mtg/HMA Annual Mtg. Held: Ilikai Htl, Waikiki. Contact: AMA Dept. of Mtg. Serv.; 535 No. Dearborn St., Chicago, IL 60610.

OUT OF STATE

For information on any out-of-state programs or courses, refer to September 3, 1980 Supplement to JAMA or call the HMA Office.



"WE BELIEVE IN THE POWER OF YES."

John D. Bellinger, Chairman and Chief Executive Officer, First Hawaiian Bank.

"The most powerful word in the English language has three letters and thousands of meanings.
It's the word yes.
And it's the catalytic word that gives new meaning to any human thought or action.

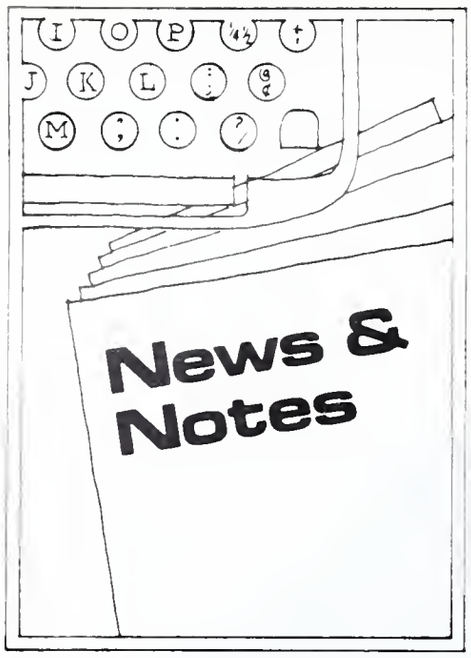
Before any mountain . . . or heart . . . was ever moved someone had to utter the magic word. Yes.

We at First Hawaiian Bank believe deeply in the power of yes. We said yes in 1858 and became Hawaii's first kama'aina bank. And we haven't stopped saying yes since. To banking innovations. To new conveniences. To you.

I think you'll find our attitude toward banking refreshing. Because there's no time like now for a bank that says yes."

Member FDIC

First Hawaiian Bank We say Yes to you.



HENRY N YOKOYAMA, M.D.

Life In These Parts

The misadventures of Hilo PHN **Patsy Matsuura** (a former Minnesotean) PHN: "Hello . . . I wonder if you would be interested in the Elderly Health Screening . . . " Patient: "No! no! Me no need house cleaning . . . Me do cleaning myself . . . "

Patient interview with newly arrived immigrant . . . PHN: "You have TB before?" Patient: "Oh yeah! I have TB before . . . " PHN: "How long you have TB?" Patient: "Me have TB long time . . . May be 5 years . . . " PHN (getting excited): "You get TB now?" Patient: "Sure Me have TB now and stereo set too."

PHN making house call on sick wife . . . The husband is working in the yard . . . "Where your camara?" PHN: "I drive Volkswagen . . . I no have Camara." "Oh, you no bring your camara for taking pictures?"

Fish caught in the Kawaihae area, West Hawaii, have caused ciguatera poisoning for 3 consecutive years. **Y. Hokama**, UH pathologist who analyzed the fish, reported that 3 po'ou (red wrasse) and a taape (yellow fish with blue stripes imported from Tahiti) were found to have high counts of ciguatoxin. Professor Hokama reports that besides the po'ou and surgeon fish, ulua, kahala, sea bass and snapper are known culprits. He warns, "Don't eat the guts, the gonads or the liver." There may be a correlation with off-shore dredging . . . Professor Hokama feels that dredging may stir up the dinoflagellates (unicellular algae), causing the organism to bloom. More than 12 people were poisoned after eating fish in the Pokai Bay area after dredging had been conducted . . . And 6 cases were reported in the area of the Honolulu airport's reef runway after it was dredged.

Kawasaki's disease has hit 35 children this year, but pediatric rheumatologist **Raquel Hicks** notes no cause for alarm. "We've seen 190 cases of Kawasaki syndrome since 1971 . . . It's a fairly common thing here . . . It tends to occur in clustering throughout the year and the last cluster was in early 1978 when we had 28 cases." Among the victims, 70% are of Japanese ancestry. The youngest child treated was 3 months old and the oldest an 8-year-old. Coronary aneurysms are the most devastating of the complications, but only 20% of the cases develop coronary aneurysm, and only 1% of all cases end in death. Raquel Hicks and **Marian Melish** have been investigating the disease since 1971 in Hawaii. Their work is funded by grants from the National Institutes of Health and from the Hawaii Heart Association. Acute symptoms include: fever for 5 days, blood-shot eyes, inflamed throat unresponsive to antibiotics, blotchy raised rash, purple-red and fissured lips, "strawberry" tongue, purple red discoloration and exfoliation of the palms and soles, toes and fingers, lymphadenopathy of the neck, generally on one side, diarrhea, abdominal pain, lethargy, and jaundice. Orientals are 10 times more susceptible than Causasians. In Japan, 14,000 cases have been reported since 1976

The State of Hawaii and the Hawaii Society of Anesthesiologits have reached a court agreement in which the doctors have agreed to the following: The society will refrain from: agreeing among its members to use any particular fee schedule or relative value guide to determine fees; engaging in threats or acts of coercion with the purpose of causing third party payers, such as HMSA, to adopt any particular fee schedule; acting as an agent for the doctors in connection with any decision to accept or reject terms of Medicaid standard provider contracts, or participating in or advocating any agreement not to provide services to Medicaid patients. The agreement approved by Circuit Judge **Toshimi Sodetani** will remain in force for 5 years . . . The agreement was reached when the antitrust division of the State Attorney's office charged the society with engaging in "group boycott" by threatening to withhold their services from the Medicaid program after efforts failed to get a better fee schedule. The State's attorneys charged that the Society had, from 1977 through Sept. 1980, "engaged in collective, coercive activities to obtain an increase in the payment of fees by the State's Medicaid program, administered by HMSA. When the anesthesiologists were unsuccessful in obtaining fee increases, they collectively attempted to enact a new relative value scale which would have resulted in a hidden 23% fee increase." Former antitrust chief **Robert Miller** charged that "the activities by the Society amount to a price-fixing conspiracy in violation of the Sherman Act." (Ed. Sherman Act, rot!! What's the difference when a union of physicians decides to strike for greater pay and a union of government or non-government workers strike for higher wages? The only difference, as we view it, is that the union of physicians (60 in number) was too small to be an effective fighting force, financially and otherwise . . .)

Bram Vanderstock, the 65-year-old physician deputy director at Waimano Training School, as a young Dutch airman, during WWII, was one of only 3 of 76 Allied airmen who succeeded in escaping to England from Stalag Luft III in March, 1944. Bram had been an ace fighter pilot with the Royal Air Force. He took part in 4 escapes from a POW camp after being shot down and captured, and participated in numerous more escapes from occupied territory . . . Bram spent 14 days crouching in the muck under the boiler room of a ship going to England, and masterminded the "Soldier of Orange" spy plan carried out by a childhood friend. Later, he headed one of the War's most widely acclaimed Spitfire squadrons. It was Bram's story that formed much of the fodder for **Paul Brickhill's** now famous documentary, "The Great Escape" and the movie based on it . . .

"Punaluu is about to get a really brainy resident: Neurosurgeon **Maurice Silver** of Encino, Calif., just bought a home . . . " (Don Chapman, Apr. 24).

Kahumana is a psychiatric facility on 14.1 acres of agricultural land in the windswept valley back of Maili . . . Eleven staff members get room and board and $10 a week, and 10 resident patients — all with varying degrees of schizophrenia — get a chance to begin life again. In addition to its residential facilities, Kahumana (meaning "power of the Spirit" or "reverence for the life force") provides a full-time psychiatric outpatient clinic for the Waianae Coast. Psychiatrist Sister **Irene Solzbacher** has a caseload of more than 100 . . . It is the brain child of psychologist **Frances Sydow** and Father **Phil Harmon,** a Catholic priest. It has the support of most of the Waianae community, except for a few neighbors and the Waianae Farm Bureau who fear another state hospital in the making . . .

In April, **Neal Winn**, HMA president, was present at a fund-raising dinner for Sen. **Richard Wong** when Sen. **Neil Abercrombie** started to choke. Neal tried the Heimlich maneuver on Neil . . . The senator's usually mellifluous baritone is now a soft rasp, and Neil said, "The Senate will be spared any of my speeches for a couple of days." "It happened because I've been forced to wear a tie for the past couple years." (Don Chapman, Apr. 14).

In March, Sen. **Duke Kawasaki** and members of the State House Committee on Health agreed to spend $2 million on local research on interferon. Opposing the measure were the American Cancer Society, HMA and State Department of Health . . . **John Keenan**, chairman of the HMA cancer committee, had to fight tooth and nail to convince Duke Kawasaki and his cohorts that research programs were already underway on the

Mainland and that Hawaii would benefit from their results. John had to argue that Hawaii was too small an area to yield any meaningful results from research into interferon, and the money would be wasted. The Duke responded, "I don't understand why you're unwilling to take appropriated funds so HMA can participate in this research." When House Finance Chairman **Tony Kunimura** asked where Kawasaki expected to find the $2 million, the Duke answered, "I'm going to oppose pay raises for the State executives and judges." (Ed. Interesting reversal of roles . . . The legislators are endorsing funds for medical experimentation and the physicians are opposed to it . . .)

An officer from HPD took a prisoner to Queen's emergency to get stitched up. While Dr. **Andy Schwartz** was sewing on the prisoner, the cop noticed a loose button on his shirt . . . "You're in luck," said Dr. Schwartz. "I come from a family of tailors." (Don Chapman, May 13).

Construction workers uncovered several burial sites on the Kawela Plantations development on Molokai. Hawaiian activist Dr. **Emmett Aluli** of Kako'o Kawela charged the contractors with desecration of the gravesites and disinterment without a permit. Emmett reported about 8 or 9 gravesites were run over by a bulldozer cutting a roadway, and that bones of the gravesites were strewn over 20 or 30 yards of the newly laid road . . . Developer Sen. **Wadsworth Yee** has provided for a site survey by the Bishop Museum to correct the situation . . .

A Canadian visitor to Kauai learned to his dismay that alcohol and scuba diving do not mix. He was found unconscious in 20 feet of water off Koloa Landing. He was rushed to Kauai Veterans Memorial Hospital, where **Robert Overlock**, who specializes in hyperbaric medicine, and his volunteers placed him in the recompression chamber for over 5 hours, then in a respirator for 56 hours. The visitor went home safe and sound. Robert said the man almost died several times of "near-drowning" syndrome . . .

Kapiolani-Children's Medical Center was awarded checks totaling $48,714 by the March of Dimes Chapter of the Pacific. **Rodney Boychuk**, KCMC neonatologist and program director of the March of Dimes' grant, received $41,717 for a preventive education program to establish a close link between the KCMC Neonatoal Intensive Care Unit and Oahu and neighbor island professionals. The second check for $6,796.00 was presented to **David Easa** for the purchase of 2 life-saving innovative monitors for the Intensive Care Unit . . .

Personalities . . .

Pediatrician **Fernando Atienza** regularly dons his jogging togs, ties a folded bandanna to his forehead, waves goodbye to his wife who drives the car home, and jogs the 15 miles to his Hawaii Kai home from his office at Kuakini Medical Plaza . . .

One April evening we met **Roger Ogata** at the Ruger Theatre, where the musical "Oliver" was playing. We wondered why Roger was beaming so happily, until we learned that his son was playing the lead role of Oliver . . . And what a performer . . . He touched everyone's heart strings with his superb singing and acting . . .

A surgeon in town (who is also a 5th rank GO player) was, as a 16-year-old, riding his bike home . . . He happened to glance up and wondered about a large parachute floating down over his city . . . He fortunately turned into a narrow lane flanked by homes when the "Pika Don" (the flash and the roar) happened . . . He picked himself out of the rubble, miraculously unaffected by the atomic holocaust of Hiroshima . . . (As related by **Fred Reppun** . . .)

Ed Furukawa's Repertoire

There once lived a hermit
 name Dave
Who kept a dead whore
 in his cave
He says, "I'll admit I'm a bit
 of a s - - -
But look at the money
 I save! (Necrophilia)

What do you get when you cross a rooster with an owl? . . . You get a cock that stays up all night . . .

A Vassar grad met a Harvard grad from the Mainline . . . He took her home for dinner to meet his parents. Later, when driving home, she asked, "How did your parents like me?" "Mother thought you were a bit uncouth." "Uncouth? Did you tell her that I'm a Vassar grad summa cum laude?" "Yes, I did." "Did you tell her I live on Beacon Hill?" "Yes, she knows." "Did she notice that my manners at the dinner table were perfect?" "Yes, she noticed." "So where does she get this uncouth shit!"

Sportsmen

It was once again Member-Guest Day at Waialae, and our host, Francis Oda, who hadn't played for a whole month, (but who at least went out to hit a bucket of balls the day before) had fortified himself with 2 beers and was soliciting bets from all comers . . . Twelve "cinch" bets thus far . . . with the likes of **Joe Nishimoto, Ike Nadamoto, Dick Omura, Phil Lee, Tom Kobara, Nobu Nakasone, Tommy Chang** etc, etc . . . Then we had the misfortune of playing with **Jim Navin** and **Bill Yarbrough**, (2 nicer guys we couldn't have picked) who were so sympathetic throughout the 18 holes that we scrambled . . . So we get up to our first tee, the 17th, and we both dub our drives into the dry river bed running obliquely across the fairway . . . Jim and Bill hit booming 300 yard drives straight down the fairway . . . As a matter of fact, Bill, who should be playing the PGA tour instead of practicing urology, was 1 over par the first 9 holes after missing 4 or 5 birdie putts . . . But it was really Jim the Navin with his 16 handicap who kept his team 9 under after 9 holes while our dic hard team struggled to get a one under for the first 9 holes . . . Then a miracle of miracles!! Francis, who had just consumed his 10th beer and a Vodka martini chaser (while we were holding our 6th beer in one hand and a screw-driver in the other), started to play like Jack Nicklaus, Tom Watson and Arnold Palmer all in one . . . We even managed to help him a few holes . . .Thus did our team manage to salvage a 7-under-par through the calming influence of the many beverages consumed . . . We also arrived at the obvious conclusion that if we are to play golf under stress, we must consume not one or two drinks, but enough to steady our overwrought nerves . . . And to top everything, we even won a tournament prize, a hair blower . . . And me with so few strands left to blow dry . . .

Professional Moves

The species, Homosapiens medicus, is hibernating for we detect very little activity . . . Perhaps it is merely retrenching for its traditional onslaught in July and August . . . In April, **Hamilton Winston** relocated from the Kailua Professional Center I to Kailua Professional Center II; radiologist **Romeo Pineda** opened at Pali Medical Building Suite 104; and FP **Joseph Mergens** took over **Kenneth Kern, Y.P. Chang** and Wilfred Ohta's former practices at 1481 So. King St., Suite 209. Abdiel Angeles opened his medical clinic at Pearl City Business Plaza Suite 311 and the Cardiology Associates (**Bradley Koizumi, Masahiro Mori**, and **Richard Reeve**) announced the opening of a second office at the Aiea Medical Building Suite 106

May found eyeman Malcolm Ing relocating to Kapiolani-Children's Medical Center, Suite 1110; orthopod Masao Takai opening a second office at the Medical Arts Building Suite 214; pediatrician **Shigeko Lau** associating with the Straub Clinic & Hospital, Inc., at its Aica Office. On the Big Island, **Rit Liu**, who does general surgery and medicine, opened his new office at Kailua Trade Center, Suite 107, Kailua-Kona.

After 4 months of negotiations between the State and the Emergency Medical Services, which is based in Kansas City, Mo., and services hospitals in 4 other states, 4 physicians will be moving to Kona to provide 24-hour emergency room service at Kona Hospital. The contract is for 2 years and the physicians may be rotated from the Mainland

Physicians' Exchange News . . .

Statistics: 537 individual members (including 515 physicians and 22 others)

24 Fronk Clinic
43 Honolulu Medical Group Inc.
Total membership 604.
Radio subscribers: 509

David Nattenberg, President of Medi-Page, Inc., is offering mobile telephones and portable phones . . . Physicians' Exchange will be subscriber contact for this service . . . Options include: 1. Rental, 2. Lease to purchase, 3. Outright purchase.

Mobile Telephone and Portable Service: $40 per month, unlimited 3-5 minute calls.

Mobile Telephone purchase: $2,500 including tax, installation, delivery charges and charger.

Touch Tone portable telephone purchase: $1,500 includes tax, installation, delivery charges and charger.

Lease-Purchase Hawaii Leasing:

3 Years	4 Years	5 Years
Mobile telephone:		
$93.60	$76.70	$66.30
Portable telephone:		
$56.60	$46.02	$39.78

Non-Equity Rental—Mobile telephone: $65 per month plus $100 installation charge.

Non-Equity Rental—Portable telephone: $45 per month.

For further details, call June Morioka at Physicians' Exchange.

Hors De Combat

The Wilcox Hospital Board of Trustees has approved the filing of a "Certificate of Need" for a whole-body-scanner. With 15 to 20 head injuries coming into the ER per month, the staff feels a Scanner would attract new medical talent, esp a neurosurgeon . . . (Ed, Wilcox better get in line . . . Kuakini, Kaiser, Castle hospitals have neurosurgeons on their staffs and still can't get their CT scans).

Antone Cacatian, Jr., a computer librarian and part-time guard, underwent neck surgery in Nov. 1977 at Straub for a numbness in his left leg, and ended up a quadriplegic. He obtained a $1.1 million out-of-court settlement. Attorneys Richard Fried, Jr. and Clarence Ching were awarded attorney fees of $360,000. . . .

Patients are being shuttled from hospital to hospital in search of an empty bed, and doctors spend hours seeking a hospital with room available . . . But SHPDA doesn't believe so . . . HMA president **Neal Winn** says, "We've got them sleeping in the halls at Kapiolani-Children's. We've got them every place." Cardiologist **Steven Wallach** says, "Sooner or later a sick person is going to die while waiting to get into a hospital or while being moved from one hospital to another in search of a vacant bed." **Douglas Bell**, who sends patients to Queen's and St. Francis, is worried that some day something serious is going to happen . . . Sometimes there are not any beds anywhere." A bed task force reports that Oahu's acute care hospitals will need 147 critical care beds by 1985. Currently, there are 124 licensed critical care beds. SHPDA has shown that Oahu currently is overbedded, and will have only 107 critical care beds by 1985. (Someone, somewhere has goofed and it sounds like SHPDA again . . .)

From Kokua Line

(April 10)

Q—Are physicians allowed to charge interest on the unpaid balances of their patients' bills?

A—Yes, they are allowed to charge interest. Doctors make it a practice, however, to first give patients notice that interest (usually 1 percent a month) will be charged, if the unpaid balance is not paid within 30 days. Not all doctors charge interest.

State Board of Medical Examiners has accepted the voluntary relinquishment of David Tien's medical license. David, a Wahiawa physician, had been charged with Medicaid fraud and drug-dispensing irregularities by the state.

Persons with Brandywine mushroom stems and pieces in 4 ounce cans are warned against botulism. The cans are carrying a code number on the bottom, *i.e.*, letters "A" through "L" followed by a "K" followed by three numerals. The second line of the code on the recalled cans starts with either "L" or "LP" followed by the numeral "1" or "2." R.F. Chittenden, consultant to the Hawaii Poison Center, warns that severe botulism poisoning has a 50% mortality. R.F. says botulism symptoms include muscle paralysis, droopy eyelids, difficulty with speech and blurred or double vision. A dry throat and difficulty swallowing may be present, and these symptoms occur anywhere from 8 hours to 8 days after ingestion of the toxin.

Elected, Honored & Appointed

George Goto and **Howard Liljestrand** and others were honored by Hawaii Planned Parenthood for their contributions to the organization and the family planning field. George, Howard, and Cosette Mulder formed the organization in 1968 as an affiliate of the Planned Parenthood Federation of America . . .

Maurice Nicholson was elected president of the Hawaii Federation of Physicians and Dentists. Elected vice presidents were **John Corboy,** and **Philip Hellreich.** Six other physicians were chosen for the board of directors.

The Hawaii Ophthalmological Society elected **Allan Kunimoto** president, **Percival Chee** VP, **Calvin Miura** secretary, **Thomas Maeda, Jr.,** treasurer and **O.D. Pinkerton,** member-at-large. The Hawaii Thoracic Society has elected **Roy Adaniya** president for this year.

HMSA elected **Albert Chun-Hoon** secretary. New physician board members are **Manuel Abundo, Mark Wentworth,** and **John Ebert** . . .

From Kauai, **Robert Berry** was appointed to the Board of Health, **Mark Henworth** to the Kauai County Subarea Health Planning Council, and **Paul Esaki** to the Board of Medical Examiners.

Internist-oncologist **Thomas Lau** has been named medical director of the hospice program at St. Francis Hospital . . .

Julia Frohlich, executive director of the Blood Bank of Hawaii, was one of 6 nominees for the University of Hawaii Board of Regents submitted by the Governor . . .

Ruben Mallari became chairman of the State Reapportionment Commission, which has the task of redrawing Hawaii's election districts. Ruben was appointed by the Supreme Court when the 4 Republicans and 4 Democrats on the Commission could not agree on a chairman. Ruben is not affiliated with any political party, and has been active in the Movement for a Free Philippines. Ruben found that he had to resign from the Board of Medical Examiners because under state law, a person can serve only on one state or county board or commission at a time

DOCTOR'S DAY . . . (March 30)

"Today is Doctor's Day, honoring the first doc to ever use ether as an anesthetic, in 1842. When this holiday began in 1933, it was customary to give your doctor a red carnation. Medical costs being what they are today, however, your doctor now gives you the carnation." (Don Chapman) (Ed . . . Drool, fellows . . . We have a sweet patient, a Mrs. Ed Yoshimasu, who has been sending us a lovely bouquet on Doctor's Day for the past 10 years)

DSSH officials were happy that the compromise version of the 1981-83 operating budget had not compromised their programs too badly . . . **Denis Mee-Lee**, chief of the Mental Health Division, was relieved to find that $338,000 to complete the designs of the new state hospital and to expand the staff had been appropriated . . . Denis says that the hospital budget requests were reduced by $134,000 in 1981-82 and $55,000 the next year, but he was optimistic: "That will hamper us a little bit, but we feel we can continue improving the services of the hospital."

State House Resolution No. 680 calls for medical records to be made available to patients trying to establish that they were exposed to DES (diethylstilbestrol). The resolution also calls on the DOH, the HMA, American Cancer Society and the Cancer Center of Hawaii to conduct educational seminars for medical professionals on DES-related diseases

Sen. **Pat Saiki** introduced two resolutions calling on the legislative auditor to look into the transactions, accounts, programs and performance of the Ethics Commission. The audit request came in

Second in a Series



TIMES HAVE CHANGED

PROFESSIONALISM REMAINS THE SAME.

Users of hearing aid equipment back in 1938 didn't have much choice. They were encumbered with a large hearing device and a quantity of cord as pictured above. (Far too much even to fit into a pocket!) Today's hearing aids are unobtrusive and do not interfere with normal daily routine or shout to the world that the wearer has a physical problem.

For almost forty-five years now, Hawaii Hearing Aids, Ltd. has been filling the needs of Hawaii's people for top-quality hearing aids and related equipment. In addition, we have been striving all this time to create a public awareness of the hearing loss problem, urge the seeking of professional help and minimize the psychological stigma attached to admitting the need for such help. All of our advertising throughout the years has emphasized the message "see your doctor first"— long before FDA regulations on the matter were ever even suggested.

We're not in business just to dispense hearing aids but to serve the people of these islands to the best of our ability. And that means first of all, seeing that they get the right kind of help. It all comes down to ethics. Responsibility. Professionalism. And that's something that time *doesn't* change.

- Hawaii's largest, oldest and most complete hearing aid and special equipment facility.
- Hawaii's only full-time Audiometer Technician.
- Bilingual staff.
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- **Impedance Audiometers and Tympanometers:** American Electro-Medics, Madsen, Grason-Stadler and Teledyne.
- I.A.C. Sound Rooms
- E•A•R™ Plugs, custom ear-plugs and ear muffs.



Dalton G. Fujii
Vice President

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response to a controversial opinion issued by the commission last year, criticizing the administration of the State's emergency medical services and HMA's influence in the program. Pat had, earlier this year, charged the ethics investigation as a "witch hunt" and maintained that the commission had exceeded its legal authority in conducting the investigation . . . (Ed. Good for Pat . . . she speaks her mind . . .) Unfortunately, the Senate Judiciary Committee filed away the two resolutions introduced by Pat

Visiting Professor. . .

Harold Soloman was the visiting professor in April and we caught his lecture on "Resistant Hypertension" at QMC Friday morning lecture

With thiazides alone, we get 70-80% control . . . With thiazides and propranolol, 95% control. Typical noncompliance case . . . Physician tells the patient: "Double the dose on your medication." Patient asks the nurse on his way out: "Doctor says double the dose . . . Since I haven't been taking the medication, should I take the first dose, or no medication at all?"

Least compliance is with potassium supplementation for thiazides . . . One out of 6 patients are on potasium supplementation . . . Only people on digitalis need potassium . . . When the serum K range is greater than 3.0 mg%, no Rx needed . . . When less than 2.5 mg%, Rx all patients . . . K supplement with diet is ridiculous . . . eg., 40 meq K means 12 oz. of bananas, 8 oz. of raisins, ¼ quart orange juice, 19 cans of beer, 7 lbs. of watermelon, or 4 milk shakes

Drop Out factors: a. Younger generation; b. less than 6 months of therapy . . .

General rule: Smaller the life-style rearrangement you have to make, the better the compliance . . .

The Heart Association says, "You take a pill and live forever." But what the patients are actually told is: 75%, to consume less salt; 80%, to change smoking habits; 59%, to lower their cholesterol levels; 66%, to lose weight; 38%, to learn to relax; only 7% are told to just take the medication.

The most difficult life-style changes are losing weight and changing smoking habits

General Rules:

1. In general people would do what they want to do . . . And will continue to do what they want to do
2. Only 7% will lose weight even with the help of a hospital dietitian
3. Spell out clearly what the the consequences of non-compliance, *e.g.*, 3 times greater mortality . . .
4. Establish therapeutic goals . . .
5. It is easier to add things to a life-style, *i.e.*, add pills . . .
6. Do not beat patient on head on first visit with a whole list of things he must do . . .
7. If you care, the patient will comply, *i.e.*, establish patient-doctor relationship . . .
8. The compliance decision is made in the first 6 months . . . The fewer the things you mention, the better the compliance . . . First visit instructions: 1. Take your medication 2. Keep your next appointment . . . 3. Telephone me if anything happens

Six months later, you may ask: "Mr. Jones, do you notice you weigh 300 lbs?" Mr. Jones: "I've been meaning to talk to you about that . . . " Physician: "If you lose weight, you may be able to stop taking the medication." (In my 12 years I've never been able to do that, but . . .)

Drug-resistant hypertension is always in concert with another disease . . . The most frequent being atherosclerotic renal hypertension and rheumatoid arthritis . . .

Miscellany

Phone rings in a stately mansion in Beverly Hills . . . Butler picks up the phone . . . "I'm calling from England. Is my wife there?" "Just a minute, sir. I'll check." Butler goes upstairs to the master bedroom and returns quickly . . . "Sir, your wife is still sleeping and there's a man in bed with her." "Go get my revolver in the living room desk, upper right drawer and shoot them both." The butler does as told and gets back to the phone . . . "Sir, I did as you told me. What shall I do with their bodies?" "Dump them into the swimming pool." "But sir, we don't have a swimming pool . . . " "What do you mean no swimming pool? Is this 633-3399?" (As told by our golfing friend, Alan Luning)

Bill died suddenly, and bereaved wife Sally had his body cremated and placed in an exquisite urn, which she placed above the ornamental fireplace . . . "Well Bill, you know how you forbade me from taking that round-the-world cruise? Well, I am all packed and ready to leave . . . Incidentally, that blue Mercedes you didn't want me to have? Well, it's parked in the garage . . . Thanks, Bill, for leaving me all that insurance money, the house and everything . . . I feel I owe you something . . . Well, remember that blow job you always wanted . . . Well, you are getting your wish . . . " She removed the urn cover, took a deep breath, went poof! Bill's ashes scattered over the fireplace . . . (Another of Walter Loo's repertoire . . .)

Physicians Speak Up

Excerpts from **J.I. Frederick Reppun**'s paper entitled, "If a Nuclear Bomb Hits Honolulu," presented at the annual meeting of the Hawaii Public Health Association:

"I am a member of Physicians for Social Responsibility (PSR) . . . This organization is concerned about the public's acceptance of nuclear warfare as a 'viable option,' or as 'limited nuclear attacks' and that 'we might win a nuclear war.'

"Interpolating PSR facts and figures, this is what might happen if Honolulu were hit by a 20 megaton thermonuclear bomb . . . Such a bomb with the destructive force of 20 million tons of TNT would create a fireball 1½ miles in diameter . . . If such a bomb were dropped on the main gate of Pearl Harbor, the 1½ mile area would include the entire Pearl-Hickam-airport-Red Hill complex, where the Navy may have upward of 3,000 nuclear warheads stored in underground bunkers or aboard ships, compounding the holocaust.

"This fireball would generate temperatures of 20 to 30 million degrees Fahrenheit. Everything in the area, the streets, the buildings and the earth below, and all living things would be vaporized, leaving a crater several hundred feet deep.

"At 6 miles from the epicenter — this would include the area bounded on the east by Houghtailing Street and Kapalama Heights and on the west by Barbers Point — all people would be instantly killed by a huge silent heat flash, traveling at the speed of light. Glass would melt and buildings would collapse when hit by a supersonic shock wave and winds of 300 miles per hour

"Within a 10 mile radius — in Honolulu this would extend from Diamond Head and St. Louis Heights to Kahe Point in Waianae and would include Kailua, Kaneohe, the Marine base and Wahiawa, destroying practically all the hospitals, clinics and doctors' offices on Oahu — the blast wave, 180-mile-per-hour winds and fires would inflict almost total casualties, with at least 50% dead and 40% injured. Even at 20 miles from the epicenter — which would encompass all of Oahu, with some deflection upward by the mountains — 50% of the people would be killed or injured by the direct thermal rediation and blast pressures . . .

"In an all-out nuclear exchange, all major population and industrial centers would be hit, both in the U.S. and in the U.S.S.R. Such an exchange would be complete in one hour! And it could destroy most life in the Northern Hemisphere

"We physicians have every right to be heeded when we spread the word that an 'accident' could lead to 100 million casualties on each side

"The physician must participate in what may be the last or terminal moral conflict, testing 'whether the intelligence of man, when turned to social responsibility, can prevail over his intelligence when obsessed with techniques of destruction,' as the editor of the New England Journal of Medicine phrased it 20 years ago. 'Could any therapeutic ad-

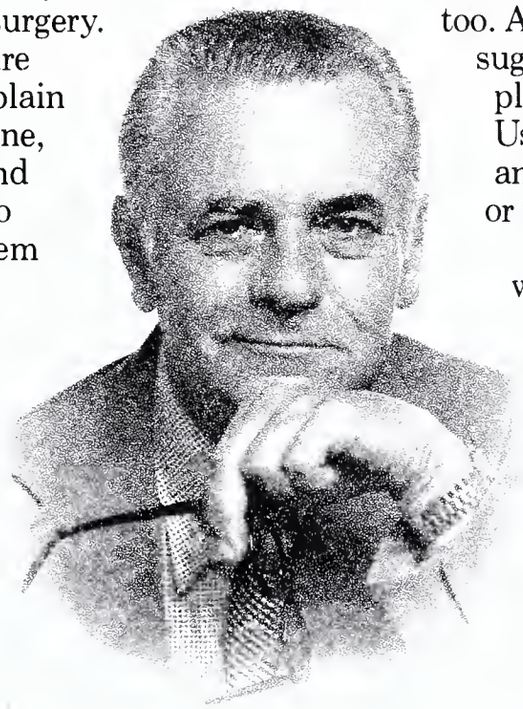
From what our HMSA members tell us, more doctors seem to be perfecting that old fashioned 'bedside manner.'

To the patient, every illness is serious, especially surgery. Today more doctors are taking the time to explain what is going to be done, why it's being done and how much it's going to cost. Patients, too, seem to be more concerned and willing to talk about these important matters.

We think these are both healthy signs. We can all do our part to promote this kind of helpful dialogue.

We'd like to hear from you, too. Anytime you have a suggestion or question, please let us know. Usually we can have an answer for you in a minute or two.

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Old Fashioned Dialogue is Back.

HMSA Utilization Review Department
Ph: 944-2355

HMSA

vance, or any scientific medical discovery provide any more meaningful service to mankind, whose health we physicians have taken an oath to protect?'

"This, I believe. This is why I am a member of Physicians for Social Responsibility. To this, I intend to dedicate my remaining life and energies, for the sake of my patients, their children and their children's children, as well as for the sake of my progeny.

"If all physicians of the world joined PSR, we might, by sheer numbers, prevail over the evil forces of darkness."

Dermatologist **Norman Goldstein** says Hawaii's fun in the sun reputation may be the reason Hawaii has the highest incidence of skin cancer and malignant melanoma in the world. Caucasians in Hawaii develop melanoma about 4 times more frequently than they did 10 years ago. Increased sunspot activity and the depletion of the ozone layer which filters some of the sun's ultraviolet rays may be the reason

Hawaiians, Filipinos, Polynesians or any people with dark skin tone are less likely to develop melanoma, but they aren't completely protected. In 1979, the Hawaii Tumor Registry recorded 71 cases of melanoma, 55 in Caucasians, as compared to 13 Caucasians, compared to a total of 17 melanoma cases 10 years before . . . During the 5-year-period from 1975 to 1979, the Hawaii registry recorded 51 deaths from melanoma . . . Nationally, 4,600 deaths annually result from malignant melanoma . . . Norman originated the cryptic letters "EYBSOYB," adopted by the Cancer Center, to encourage people to "examine your birthday suit on your birthday" . . . He also recommends the daily use of a sunscreen containing PABA, and staying out of the sun, especially between 10 a.m. and 2 p.m. Those who use oils or grease for tanning or moisturing their skins are "sauteing their skins because oil preparations magnify the effects of sunlight."

Writing in Commentary, our editor **Harry L. Arnold Jr.** warns that we have not learned from our experience with the 1919-to-1933 prohibition of alcohol, and we are repeating our mistakes now with marijuana. We have excerpted as follows:

" 'What we learn from history is that we learn nothing from history' — Thucydides, 430 B.C. 'Those who cannot remember the past are doomed to repeat it' —George Santayana, 1930 A.D.

"Did we learn a lesson from this? (referring to the prohibition of alcohol) We did not. We went right ahead and attempted the 'prohibition' of a far less harmful drug, tetrahydrocannabinol, in its various forms of marijuana (pot) or hashish. History has, as usual, repeated itself. We have again created a huge criminal industry, international in scope, engaged in supplying marijuana to anyone who wants it.

"The prohibition of marijuana, like the prohibition of alcohol, has been an utter failure. If we were succeeding in preventing its distribution, there might be some slight excuse for the billions of dollars poured into the effort, and the often inordinately severe and even cruel punishment imposed on perpetrators of the victimless crime of possessing the substance. "Malum prohibitum," as Gordon Liddy called it: a wrong by definition — not "malum in se," or an evil in itself.

"We might well have been warned off by the failure — worse than mere failure, really — of the national prohibition of the sale of narcotics. This has not been prevented by legislative fiat, either. No one who wants heroin need go without it; all it takes is money, for the price has been forced so high by the international criminal industry whose business it is to supply it, that an addict must steal, burglarize, or rob almost every day, or engage in prostitution to finance the habit.

"The total bill paid by U.S. citizens to supply heroin and cocaine to the addicts among us — in terms of 'enforcement' costs and crimes committed to finance their habit — is staggering; it adds up to many billions a year.

"Because the price is artificially high, the criminal suppliers have a stake in recruiting new addicts among school children and young adults, so they will have more customers. And the prevention doesn't work! It is an incredibly costly failure, on an even grander scale than the 'prohibition' of alcohol was.

"We have proved, tragically, the truth of Santayana's cynical observation. We have been unable to remember the past — and we are doomed to repeat it. The solution is obvious. Legislation couldn't stop the use of alcohol, and it hasn't stopped, and cannot stop, the use of marijuana or narcotics. We had better face up to reality and stop dreaming impossible dreams. As a first and minimum step, we ought to legalize marijuana — and tax it."

Chairman of the HMA Committee on Pharmacy and Drug Abuse, Russell Hicks, says "Although cocaine is not physically addictive, it is not a safe drug by any stretch of the imagination, because of the physical effects it has, and the psychologic craving it can generate." Russell describes cocaine as a stimulant (rather than a narcotic) very much like the amphetamines . . . The effects of stimulation and euphoria which users feel are the result of its action on the central nervous system . . . It stimulates the brain cells by affecting certain chemicals to make one feel more energy and alertness."

A J.F. McDaniel is critical of **Willis Butler**'s recent commentary on El Salvador, but what we found interesting and perhaps even true was McDaniel's following commentary on physicians: "What so many of us find annoying about Butler's recurring anti-American, pro-Communist propaganda is his use of the 'M.D.' after his name. To those whose only contact with physicians has been as a patient quickly restored to health and vigor, the profession is one held in highest esteem. Logically what such a person says will be given greater credibility than is accorded a nondescript writer or spokesman . . . To correct a possible misapprehension by the public, I would like to speak from experience, having associated closely with large groups of physicians for over 20 years . . . To my astonishment I learned early on that perhaps there is no segment of our society so totally misinformed, misguided and prone to hysterial, irrationally false dogma and radical causes. And there is an obvious reason for this phenomenon. They have to spend so many years and so much concentrated effort to acquire and maintain the skills of their profession they have no time to learn anything else.

"Butler, using his "MD" to impress unwitting readers, proves the rule rather than the exception." (Ed. We confess Mr. J.F. McDaniel may have us pegged right and it is time for some serious self reflection)



"We can do without the idiot cards, Mr. Trimble!"

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Hawaii Academy of Family Physicians' Newsletter

DON AND MARLIES FARRELL

We welcome two **new members: Verne Adams,** a former member of our chapter, now lives in Captain Cook in retirement and becomes an inactive member. **Sharon Lawler,** a third year student at UH Medical School, has joined as a student member.

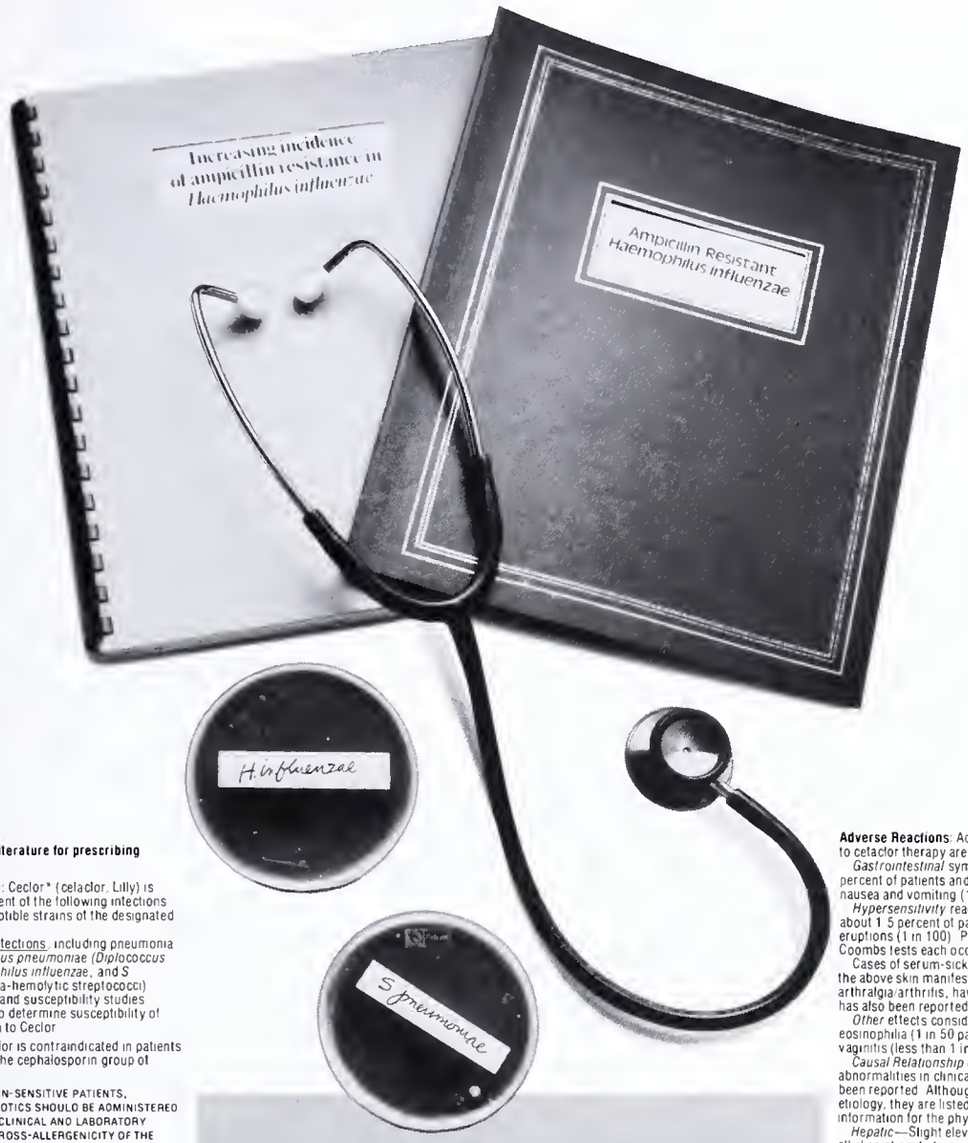
Congratulations to several student members who became new M.D.s recently: **Gary Crawford, Michael Ling, Nancy Morioka, Luis Ragunton and James Walker.** We hope they will continue their interest in family practice as they go on to further training.

Congratulations, also, to our resident members who completed their training at the Kaiser-UH residency program. **David Gilmour, Lloyd Kobayashi and Marcia Sablan** are the last graduates of the only FP residency program in Hawaii, except for the military residencies at Tripler. The Kaiser program came to an end because no further funding was available from the federal government and funding was not available locally. **Dave, Lloyd and Marcia** are an asset to their profession and we wish them well.

The American Academy of Family Physicians annually recognizes those members who give unselfishly of their time and experience as preceptors. Certificates were presented to the following members of our chapter: **John Aoki, Ernest Bade, Norberto Baysa, Tom Cahill, Frederick Dodge, Clifford Drucker, Eileen Exton, Milton Howell, Doris Jasinski, Harold Machigashira, Rod Miller, Gwen Nishimura, Helen Percy, Marc Shlacter, Richard Tesoro, James Tsuji, Mark Wentworth, Patrick Walsh, Arch Wigle and Nathan Wong.** We are grateful to these members and would like to remind you that many more preceptors are needed. If you are interested, please call **Frank Tabrah** at UH Medical School at 948-8287.

The July **dinner meeting** was graciously hosted by **Drs. Lily Ning** and hubby **Jerry Prentiss** at their beautiful Kahala home. Members, spouses and guests enjoyed a delicious dinner and afterwards heard

An added complication... in the treatment of bacterial bronchitis*



Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

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cefaclor
Pulvules®, 250 and 500 mg

Brief Summary
Consult the package literature for prescribing information.

Indications and Usage: Ceclor* (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE)

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e g , pressor amines, antihistamines, or corticosteroids

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms Careful observation of the patient is essential If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly)

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below

Gastrointestinal symptoms occur in about 2 5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90)

Hypersensitivity reactions have been reported in about 1 5 percent of patients and include morbilliform eruptions (1 in 100) Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients

Cases of serum-sickness-like reactions, including the above skin manifestations, fever, and arthralgia/arthritis, have been reported Anaphylaxis has also been reported

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200) [103080R]

* Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S pneumoniae* or *H influenzae* †

Note Ceclor* (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever See prescribing information.

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1 Antimicrob Agents Chemother , *8* 91, 1975
2 Antimicrob Agents Chemother., *11* 470, 1977
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5 Current Chemotherapy (edited by W Siegenthaler and R Luthy), II. 880 Washington, D C American Society for Microbiology, 1978
6 Antimicrob Agents Chemother , *13* 861, 1978
7 Data on file, Eli Lilly and Company
8 Principles and Practice of Infectious Diseases (edited by G L Mandell, R G Douglas, Jr., and J E Bennett), p 487 New York John Wiley & Sons, 1979

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

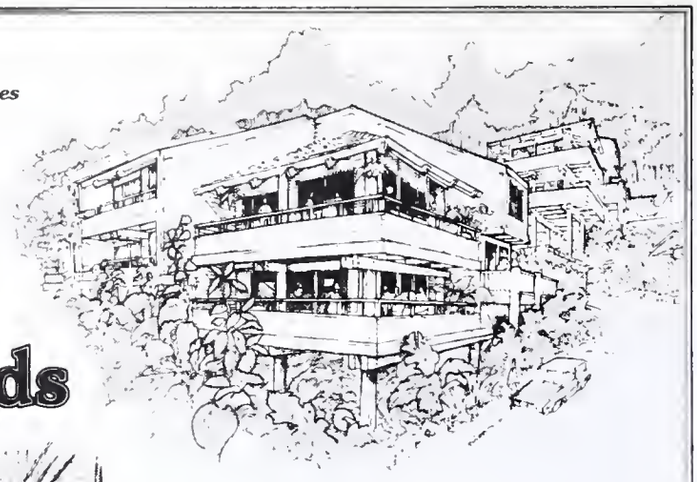
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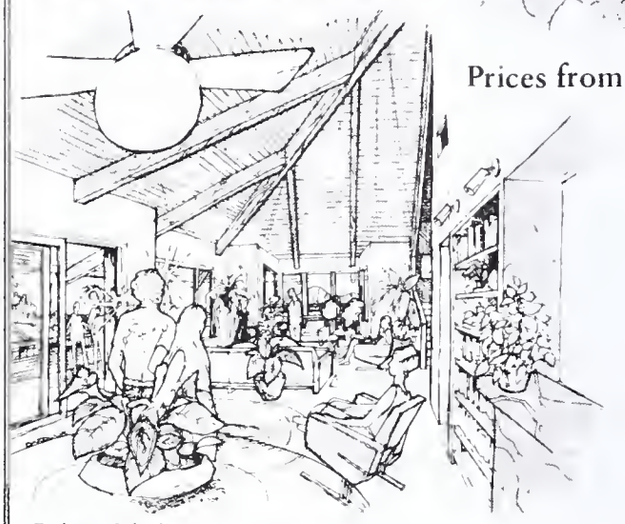
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presentations by **Raymond Taniguchi** on "Management of Acute and Chronic Low Back Pain" and by George Bolian on "Health Manpower in Hawaii in the 1980s." Plan to attend the next dinner meeting in September; notices will be in your mail soon.

The upcoming **AAFP Annual Meeting** in Las Vegas promises to be a worthwhile event, with an outstanding scientific program, as well as several big social events being offered, and up to 34 hours "P" credit available. Las Vegas being a favorite spot for islanders, our chapter should be well represented at this year's meeting. **Tom Cahill** and **Don Farrell,** Hawaii delegates to the AAFP Congress, are open to members' suggestions as to resolutions to bring before the congress. Do share your ideas and concerns with them. Their addresses and phone numbers are available from Marlies Farrell, at 235-3115.

Don Farrell will also present a paper, titled "A Test of Cost Effectiveness of Family Practice," before the Scientific Assembly. He is participating in a first-time event, the Research Forum, which will feature papers selected in open competition.

Need CME hours? The USC program in August, the Canadian meeting and the AAFP Annual Meeting all offer many high quality "P" credits.



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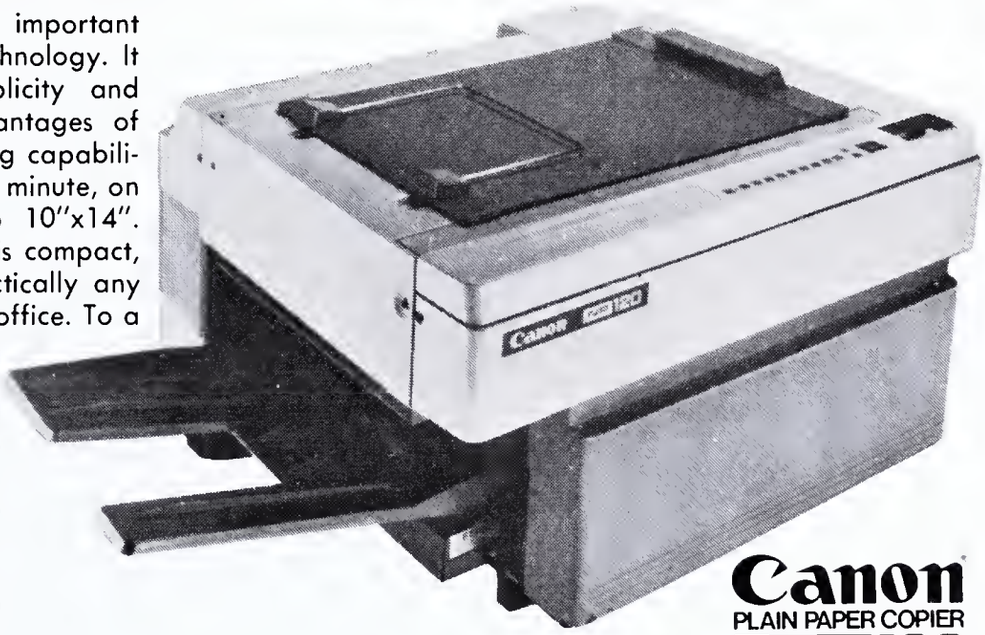
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SEPTEMBER 1981
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Hawaii Medical Journal

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Feelings vs.

Some people feel that I am misused and overused and that I'm prescribed too often and for too many kinds of problems.

The FACT is that approximately eight million people, or about 5 percent of the U.S. adult population, will use me during the current year. By contrast, the national health examination survey (1971-1975) found that 25 percent of the U.S. adult population experiences moderate to severe psychological distress. Additionally, studies of patient attitudes revealed that most patients have realistic views regarding the limitations of tranquilizers and a strong conservatism about their use, as evidenced by a general tendency to *de*crease intake over time. Finally, a six-year, large-scale, carefully conducted national survey showed that the great majority of physicians appropriately prescribe tranquilizers.

Some people feel that patients being treated with anxiolytic drugs are "weak," can't tolerate the anxieties of normal daily living, and should be able to resolve their problems on their own without the help of medication.

The FACT is that while most people can withstand normal, everyday anxieties, some people experience excessive and persistent levels of anxiety due to personal or clinical problems. An extensive national survey concluded that Americans who do use tranquilizers have substantial

Facts

justification as evidenced by their high levels of anxiety. It was further noted that antianxiety drugs are not usually prescribed for trivial, transient emotional problems.

Some people feel afraid of me because of the stories they've heard about my being harmful and having the potential to produce physical dependence.

The FACT is that there are thousands of references in the medical literature documenting my efficacy and safety. Extensive and painstakingly thorough studies of toxicological data conclude that I am one of the safest types of psychotropic drugs available. Moreover, I do not cause physical dependence if the recommended dosage and therapeutic regimen are followed under careful physician supervision. However, I can produce dependence if patients do not follow their physicians' directions and take me for prolonged periods, at dosages that exceed the therapeutic range. Patients for whom I have been prescribed should be cautious about their use of alcohol because an additive effect may result.

Many of the most knowledgable people feel that I became the No. 1 prescribed medication in America because no other tranquilizer has been proven more effective. Or safer.

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For a brief summary of product information on Valium (diazepam/Roche) ℞, please see the following page. Valium is available as 2-mg, 5-mg and 10-mg scored tablets.

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diazepam/Roche

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).
The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.
Dosage: Individualize for maximum beneficial effect. *Adults.* Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d., alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d., adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).
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Editorials

Eye Month

You may have felt "over exposed" to the Hawaii Ophthalmological Society's EYE MONTH campaign. This seems understandable, because the word "ophthalmology" appeared before the public several thousand times during April.

Begun last year as a way to improve the public's awareness of medical eye care and the role of ophthalmologists, the political overtones ("In Eye Care, **M.D. Makes a Difference**") are easy to see. Yet, behind the hoopla was a more serious side: to show that ophthalmologists care, and that physicians can work collectively for the public health.

During EYE MONTH ophthalmologists gave out thousands of balloons and pamphlets in shopping centers, appeared repeatedly on TV, and enlisted the Boy Scouts to promote their activities at the Makahiki. Ophthalmologists gave a dozen slide shows to senior citizens and service clubs, and twice filled the Mabel Smythe auditorium for their spectacular video and slide show. With the Lions, they screened about 1,000 people for glaucoma and vision, and actually opened their offices on a Wednesday afternoon for free screening tests. Their eye safety campaign appeared on 300,000 shopping bags, and their slogan contest drew almost 50,000 entries! They gave away $1,000 in cash prizes, plus a lot of free glasses, contacts, eye exams, and advice.

By enlisting the support of the visual rehab folks, the Lions, and local opticians, ophthalmologists set the stage for a more broadly based campaign in the future.

The EYE MONTH image, that of physicians giving their time and money to promote the public interest, has proven a very positive one which other specialty groups might emulate.

In this age of changing approaches to health care, the patronage goes to those providers who are perceived as caring. The public certainly ought to feel that our eye docs care, and pretty soon some people may even be able to spell "ophthalmology"! JMC

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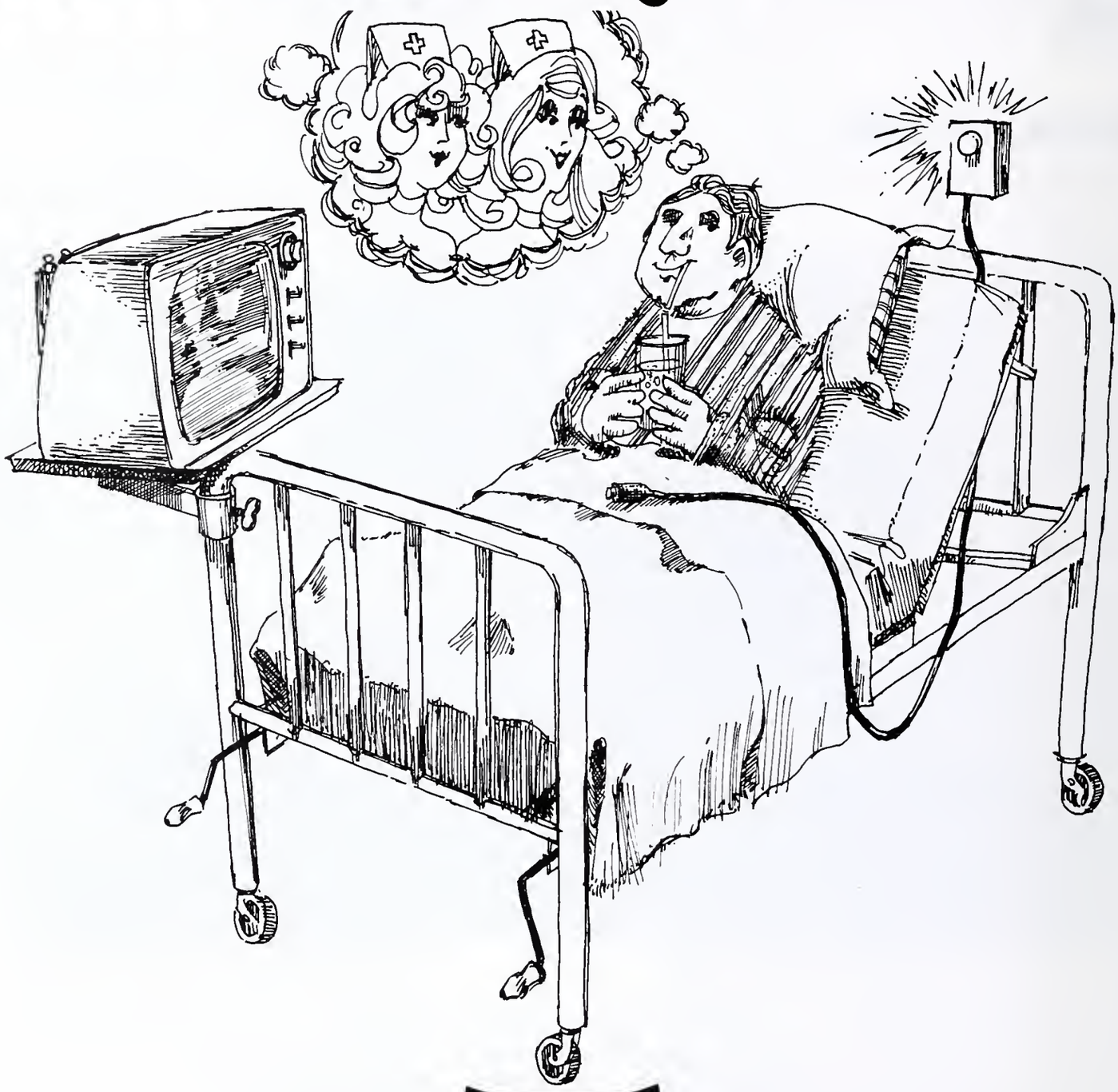
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Over the Editor's Desk

HARRY L. ARNOLD, JR. M.D.

Silicone bag breast implants may burst as a result of a relatively minor blow, James Mason reports in the June issue of the *Archives of Dermatology*.

* * *

World Is Too Much With Us Department, Pollution Division: polychlorinated biphenyls, which were being put into damn near everything until 1977, can also cause hypertension. Fish — fresh water fish, luckily for Hawaii citizens — is the only major dietary source of PCB's.

* * *

Effective and simple IUD removal hooks are offered by Amko Manufacturing, 41 Oak Ave., Bellmawr, NJ 08031. Catalogue No. G-618 for open IUD's like the "Copper 7," or G-617 for the simpler bendable stainless steel hook.

* * *

The eye men have gotten their act together: the 9,900-member American Academy of Ophthalmology and the American Association of Ophthalmology (all too often spelled Opthamalogy) merged on July 1 with the Academy, increasing its emphasis on socioeconomic problems.

* * *

Interested in educational medical & surgical movie shorts? Write Abbott Laboratories at 565 Fifth Avenue, NY 10017, for their list of such films, some free, some for a fee. The variety is fantastic! Or look at the catalogue at the HMA office.

* * *

CHAMPUS inpatient maternity coverage for pregnancy-associated emergencies no longer requires a nonavailability statement. This is retroactive to June 1, 1977, and the claim deadline is extended to December 31, 1981. For claims for care received in 1981, the deadline is December 31, 1981.

* * *

For information on a 5-day course in noise control for buildings, manufacturing plants, equipment, and products, in Washington, Houston, Santa Monica, Kansas City, Cambridge (MA), and Chicago, write Miss Gloria A. Cianci, Bolt Bernake & Newman, Inc., 50 Moulton St., Cambridge, MA 02238.

* * *

The American College of Chest Physicians meets in the San Francisco Hilton October 25-29, 1981.

* * *

Mercury vapor a potential hazard in your office — or your dentist's? A tiny portable monitor has been made available by Siemens Gammasonics, Inc., 2000 Nuclear Drive, Des Plaines, IL 60018.

* * *

Abbott is now marketing a Rubazyme Diagnostic Test Kit for fast, simple, inexpensive, reliable immunoassay for rubella. The kit will perform 100 tests.

* * *

A new, fast differential blood smear stain, Hemacolor (TM), is offered by the Harleco Division of EM Industries, Inc. Write to Harleco, 480 Democrat Road, Gibbstown, NJ 08027. It is so intense that it can be used for microorganisms or spermatozoa as well as blood cells.

* * *

The AMA will sponsor a national conference on environmental toxins and human health, September 14-16, in Arlington, VA. Write the AMA for details.

* * *

In the July *Realtor's Digest*, Lowell Ponte says that once DNA is damaged by ultraviolet radiation, there is no recovery from it. What utter nonsense! This state prevails only in children with xeroderma pigmentosum, nearly all of whom, without the most meticulous care for sun protection, die of skin cancer before they can grow up. If Mr. Ponte were right, there wouldn't be any adults around to worry about sun screens! Irresponsible journalism!

* * *

Quackery marches on, even if it is now often referred to as an "alternative health care practice." Human chorionic gonadotropin ("HCG") is still being offered as a help in weight loss programs. It worked, in one recent study of 200 overweight patients, a little less well than a placebo. By whatever name, it's quackery.

* * *

Could you use a transparent plastic hood for controlled administration of oxygen to infants weighing up to 3.3 pounds? Such a device has just been produced by Katan V.B. in Holland. Write to the Consulate General of the Netherlands, Economic Section (42), One Rockefeller Plaza, New York, NY 10020.

* * *

Carbonless copy paper can cause a skin rash, and that's the worst kind of rash there is. Ask about it when office personnel have a persistent rash of fingers or eyelids. Read about it in JAMA for June 12, 1981.

* * *

Bendectin, given for nausea in pregnancy, was found NOT to be associated with birth defects in a recent study in Atlanta (JAMA, June 12).

* * *

For a free "wrap session" on new surgical draping techniques, write 3M, Dept. SU81-36, Box 33600, St. Paul, MN 55133. Indicate specialty.

* * *

Don't show off by swallowing a newt! Some of them are as poisonous as *fugu*, possessing the same poison, tetraodotoxin, as the balloon fish have. No newts in Hawaii, though, except in pet stores.

* * *

Pity! Just as confidence in the omnipotence of interferon wanes, its production zooms: Cetus Corporation is about to produce it in quantity from genetically modified B. subtilis.

* * *

DuPont announced in June a $6 million grant to Harvard for research in molecular genetics.

* * *

Would you like a free office efficiency checkup and recommendations? Write Control-o-fax, 3070 West Airline Highway, Box 778, Waterloo, IA 50704.

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A check for $17 will bring you a copy of a new AMA book, "Drug Abuse: a Guide for the Primary Care Physician." Send it to Order Dept., OP-323, AMA, Box 831, Monroe, WI 53566.

* * *

An excellent postgraduate meeting will be held in Atlanta, Georgia, October 26-29, under the auspices of the Interstate Postgraduate Medical Association of North America, Box 1109, Madison, WI 53701.



Allergan-Herbert Laboratories presents a check to the Hawaii Medical Association's Skin Cancer Education Fund. Left to right are David Saylor, Director of Distribution and Trade Relations, Yvonne Beaton, local representative for Allergan-Herbert Labs, and Neal E. Winn, M.D., President of Hawaii Medical Association.

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This little "limu" caused a sore mouth . . .

Escharotic stomatitis caused by the "Stinging Seaweed" *Microcoleus lyngbyaceus* (formerly *Lyngbya majuscula*)

Case Report and Literature Review

J.K. SIMS, M.D. *and* RICHARD D. ZANDEE VAN RILLAND, M.D.

Microcoleus lyngbyaceus (formerly known as *Lyngbya majuscula*)[1] has been recognized as the primary etiologic agent of stinging seaweed dermatitis in the State of Hawaii since the late 1950's.[1-5] This dark green olive drab finely filamentous member of the blue-green phylum of algae (cyanophyta) clings to other seaweeds, and forms matted felt-like masses (Figure 1) which vaguely resemble edible seaweeds, or "limu." To date there have been no published medical reports regarding the consequences of human consumption of this toxic seaweed, although deaths have been reported in horses feeding on toxic *Lyngbya majuscula* Gomont (*i.e.* *Microcoleus lyngbaceus*) on beaches of Ceylon (*i.e.* Sri Lanka). Herein are the first reported human clinical manifestations of an inadvertent incomplete oral ingestion of a toxic strain of *Microcoleus lyngbyaceus*, collected from the North Kohala area of the island of Hawaii.



FIG. 1

Specimen of the toxic stinging seaweed *Microcoleus lyngbyaceus* (formerly known as *Lyngbya majuscula* Gomont 1893). Although this seaweed is one of the blue-green algae (*i.e.* phylum Cyanophyta) its color is actually a dark green olive drab. This stinging seaweed is finely filamentous like hair or horse hair, and is velvety to the touch. The organism is usually multi-stranded or clumped, as shown, and readily clings to corals and other seaweeds, including edible seaweeds. Both the toxic and non-toxic strains of *Microcoleus lyngbyaceus* have the same appearance grossly. The deeper water (*i.e.* 80-100 foot depths) strains of *Microcoleus lyngbyaceus* are red in color.[4] Photograph made of the seaweed preserved in 10% formalin after collection by the patient at the Waianaia Gulch coastline of the island of Hawaii. Photography by Roy Cameron. Comparative references are available. [3,5] A reference specimen has been preserved.

Case Report

A 47-year-old male resident of the North Kohala area of the island of Hawaii presented to the Emergency Room of Kohala Hospital August 18, 1979, at 5:45 p.m. with the complaint of a severe burning sensation of his lips, tongue and mouth. He stated that about 10 minutes earlier he had chewed briefly on a (to him) unknown variety of "limu" (*i.e.* seaweed), which he had found at the Waianaia Gulch coastline in North Kohala, and he believed that by doing so he had been "poisoned."

He described the unusual "limu" as small, dark green drab-looking, thready masses which contained tiny oval-round pods, about 1 cm diameter, from which strands of blackish green filaments protruded, and which looked to him like "horse hair."

After chewing on this material, he found the taste to be so unpalatable that within a few seconds he removed it all from his mouth. Almost immediately a burning sensation of the anterior portion of his mouth set in which did not relent upon rinsing the mouth several times with water. He then rushed to his car and drove himself to the hospital.

Upon initial examination, all vital signs were normal; the patient was afebrile, alert, coherent, and cooperative, but was extremely uncomfortable because of an excruciating burning sensation of his lips, the anterior part of the oral cavity and the anterior portion of the tongue. He was anxious, and stated fear that the "poisoning" might spread to his throat.

The local findings were normal. Increased salivation was difficult to evaluate, as the patient insisted in rinsing his mouth incessantly with cold water. The mucous membranes and lips appeared normal.

The patient was given 50 mg diphenhydramine

From the Hawaii Medical Association Emergency Medical Services Program (Dr. Sims) and the Mililani Medical Clinic (Dr. Zandee van Rilland).
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(Benadryl) intramuscularly, and he was encouraged to rinse his mouth frequently with 3% hydrogen peroxide, normal saline and ice water. Of the three, he preferred the ice water and desired to keep ice cubes in his mouth between rinses.

He was observed for the next 90 minutes, during which local applications of viscous lidocaine were offered for pain relief, with questionnable results. When it appeared certain that the condition was not progressing, he was discharged and given Benadryl and prednisone as take-home medications.

He returned at 11:00 p.m. the same night, with identical complaints, largely because he felt he had failed to improve. Re-examination showed normal vital signs and a normal temperature. The mucous membrane of the anterior oropharynx appeared slightly hyperemic and exhibited slight congestive swelling. Discrete, punctiform breaks in the mucosa, with an occasional erosion with hemorrhagic edges, were observed at this time. The patient was carrying a bag of ice cubes and stated that sucking on ice cubes had been the only satisfactory method to afford some comfort.

He felt that the diphenhydramine, viscous lidocaine, and analgesics had not alleviated the burning pain. The patient was given hydrocortisone sodium succinate (Solu-Cortef) 500 mg I.M. and was advised to continue with prednisone 5 mg q, 6, h, and to continue to apply ice cubes locally.

On a third examination, about 24 hours after the occurrence, the mucous membranes appeared to have been scalded, and exhibited hyperaemia and congestive swelling. Several erosive lesions were present, with an occasional small fragment of partially detached mucous membrane and a patchy greyish white coating. The burning pain had begun to diminish over the preceding 12 hours and he had been able to sleep several hours. For relief, he sucked on ice cubes the first 24 hours and ate ice cream the second 24 hours.

The patient continued to improve and became free of discomfort after the third day of his injury. After two weeks all manifestations had completely disappeared, leaving no residual deficits. He was advised not to consume that type of seaweed again.

The patient kindly collected more of the toxic seaweed for gross (Figure 1) and microscopic (Figure 2) examination by the authors, and the specimen was tentatively identified as *Microcoleus lyngbyaceus* (formerly *Lyngbya majuscula* Gomont).

Literature Review

Microcoleus lyngbyaceus (formerly known as *Lyngbya majuscula* Gomont),[1] a seaweed, was the first marine plant to be conclusively implicated in producing an acute human primary irritant dermatitis, largely as a result of the evaluation of an epidemic of swimmer's itch, which occurred on



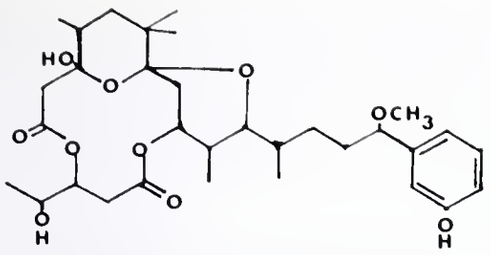
FIG. 2

Photomicrograph of several strands of the toxic stinging seaweed *Microcoleus lyngbyaceus* (formerly *Lyngbya majuscula* Gomont 1893). The organism consists of an elongated tube filled with green disks arranged like coins in a bank wrapper. One of the disks is seen from the end within the lumen of the tube (arrow). Several air bubbles are present in the field (A's). Photograph made of the seaweed preserved in 10% formalin after collection by the patient at the Waianaia Gulch coastline of the island of Hawaii. Photomicrograph by J.K. Sims, MD, with development by Roy Cameron. Comparative references are available.[5, 14-15]

the island of Oahu during the late 1950's. During July and August of 1958, more than 125 persons sustained a dermatitis in the bathing suit distribution while swimming at certain beaches, from Laie to Waimanalo, along the windward coast of the island of Oahu.[3, 5] Examination of a number of the beaches where the dermatitis was contracted revealed waters turbid with seaweed, the toxic seaweed being a dark green olive drab finely-filamentous hair-like mass which was subsequently identified as *Lyngbya majuscula* Gomont.[5] Additional surveys revealed the presence of *Microcoleus lyngbyaceus* on numerous beaches on Oahu, Molokai, and Kauai; however, not all strains were toxic. Toxic strains were recovered from Laie, Kaaawa, Kailua, Waimanalo, offshore Waikiki (at depths of 80 feet, where the organism is red in coloration), and Makaha on the island of Oahu, Hanalei on the island of Kauai, and Pilaau on the island of Molokai.[4] More recently toxic seaweed has occurred at Hauula, Kailua Beach, Kaneohe, and Hunakai-Kahala Beach on the island of Oahu, and at the North Kohala Waianaia Gulch coastine on the island of Hawaii.

Outside of Hawaii *Microcoleus lyngbyaceus* has been found in Spain, the Bahamas, southeast Florida, and throughout the tropical Pacific and Indian oceans.[4, 6-7]

This seaweed may be found on the beach and in seawater from the intertidal zone to a depth of 100 feet. The season of stinging seaweed dermatitis is given as June-September in Hawaii, and March-September in Florida.[5] It is not known, however, whether this seasonality reflects the in-



DEBROMOAPLYSIATOXIN

FIG. 3

Structure of debromoaplysiatoxin.[10] This substance has been isolated from the stinging seaweed *Microcoleus lyngbyaceus* (formerly *Lyngbya majuscula* Gomont 1893).[10] This heat stable material is a toxic irritant which produces acute inflammation and a pustular folliculitis in human beings.[10, 13] Photography by Roy Cameron.

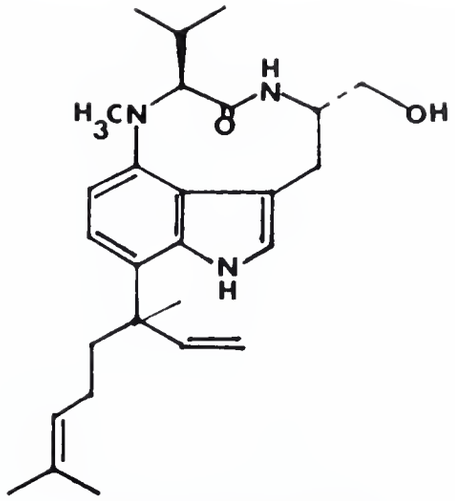
creased recreational beach use exposure to seaweeds during the summer months, seasonal conversion of non-toxic seaweed into toxic strains, proliferation of toxic seaweed during these months, heavier reef and beach deposition of toxic seaweed by onshore wind and water currents during the summer months, a combination of these, or other factors.

Several toxins have been isolated from *Lyngbya majuscula* Gomont (*i.e. Microcoleus lyngbyaceus*),[4, 7-11] including two toxins whose chemical structures have been completely elucidated:

- debromoaplysiatoxin (Figure 3)[10]
- lyngbyatoxin A (Figure 4)[11]

Both substances are lipid soluble, which explains the effectiveness of warm water and soap washes, if such are utilized within 1-3 hours of the toxic exposure.[3, 5] The melting point of debromoaplysiatoxin at 105.5-107.0°C partially explains the minimal reduction of toxicity upon boiling the algae for 30 minutes.[12] Pure debromoaplysiatoxin is a toxic irritant which produces swelling, inflammation, and an inflammatory pustular folliculitis in human beings.[10, 13] Lyngbyatoxin A is an irritating vesicant in human beings.[11] The clinical manifestations of stinging seaweed dermatitis appear to be largely related to the effects of debromoaplysiatoxin and lyngbyatoxin A, with the possibility of other toxins not having been excluded.

The clinical manifestations of stinging seaweed dermatitis (Table 1) herald the phases of the clinical course.[2-3, 5] The initiating factor in stinging seaweed dermatitis consists of the prolonged contact of the seaweed with the skin, usually with the entrapment of the seaweed between the bathing suit and the skin. Entrapment of the seaweed between the bathing suit and the skin for prolonged periods produces the classic bathing suit distribution of the dermatitis: a swimshorts pattern in men and a bikini pattern in women wearing bikinis or two-piece bathing suits. Extended seaweed contact with the penis, scrotum, perineum and peri-anal tissues in males produces severe inflammation, as does contact with the peri-urethral, labial, perineal, and peri-anal tissues in females. Lesions outside the bathing suit distribution appear to be the result of prolonged contact with the seaweed while swimming, and include primarily inflammation of the conjunctivae, nasal mucosa, and lips. Markedly prolonged contact with highly toxic seaweed can produce generalized edema, generalized pustular folliculitis, and generalized lymphadenopathy. Usually stinging seaweed dermatitis is initially manifested by itching, burning, and stinging sensations within a few hours after contact with the seaweed filaments (hence the name "stinging seaweed" dermatitis). At this point, the diagnostic olive drab filaments can sometimes be recovered from the irritated



LYNGBYATOXIN A

FIG. 4

Structure of lyngbyatoxin A.[11] This substance has been isolated from the stinging seaweed *Microcoleus lyngbyaceus* (formerly *Lyngbya majuscula* Gomont 1893),[11] hence its name. Lyngbyatoxin A is a irritating vesicant in human beings.[11] Photography by Roy Cameron.

TABLE 1 Clinical Manifestations of Stinging Seaweed *(Microcoleus Lyngbyaceus)* Disorders: Dermatitis Versus Ingestion Oropharyngitis

MANIFESTATION		DERMATITIS 2-3, 5 OROPHARYNGITIS
Burning sensation	x	x
Itching	x	-
Stinging	x	x
Erythema	x	x
Erythematous papules	x	-
Vesicles	x	-
Blisters	x	-
Local irritation	x	x
Swelling (edema)	x	x
Erosion (denuded areas)	x	x
Scalded appearance	x	x
Coating (patchy)		x
Eschar	x	-
Lymphadenopathy	±	-
Scarring	±	-
Other		hypersalivation
Sites	bathing suit distribution (external genitalia, perineum, peri-anal)	mouth
Duration	10-14 days	14 days

skin site or from the adjacent bathing suit.[5] The suspected diagnosis based on the gross appearance of the seaweed (Figure 1) can be immediately confirmed by examining the seaweed under light microscopy (Figure 2),[5] using appropriate references as necessary.[14-15] More prolonged contact of the lyngbya filaments with the skin allows local erythema to develop, followed by erythematous papules. After 3-8 hours, vesicles develop, coalescing into thin-walled blisters.[3, 5] These blisters rapidly enlarge and are often denuded by the scratching process to leave raw itchy patches. These lesions resemble burns and generate constant pain. The denuded blister areas become lightly, then heavily, encrusted within several days. Resolution of the lesions requires 7-14 days.[3, 5, 13] This overall process is described as dermatitis escharotica (as opposed to dermatitis venenata), since the toxins involved have the capability of injuring the skin of virtually all normal persons, not just susceptible persons.[2, 3] The histopathology of this acute vesicular dermatitis reveals intraepidermal vesiculation, polymorphonuclear infiltration of the stratum basalis, and infiltration of the adjacent dermis by polymorphonuclear leucocytes, lymphocytes, and eosinophils,[5] the experimental histopathology induced by purified debromoaplysiatoxin being similar.[13] Culture of the vesicles has revealed a non-hemolytic streptococcus,[5] a gram-negative pigment-producing bacillus,[5, 12] and no fungi.

Another noticeable component in some cases of stinging seaweed dermatitis is a pustular folliculitis which, in severe cases, may be accompanied by lymphadenopathy. Follicular pustules and intrafollicular pustules have been produced and examined in human subjects given purified debromoaplysiatoxin experimentally,[13] indicating that debromoaplysiatoxin may be one of the primary etiologic factors promoting the development of pustular folliculitis in stinging seaweed dermatitis.

The therapeutics of stinging seaweed dermatitis consists of thorough washing of the affected area with warm water and soap, this being relatively effective if provided within 3 hours of the toxic exposure.[3, 5, 16-17] Wet compresses and bland soothing ointments (*e.g.* vitamin A and D ointment) have been effective in some cases.[3, 5] In the late 1950's, topical steroids were rarely indicated for stinging seaweed dermatitis[3] and parenteral steroids were "practically never" given;[3] however, a reappraisal may be indicated. Although a heat labile lyngbyatoxin has been reported,[18] hot water therapy (*e.g.* immersion of affected area in water at 45-50°C) has not been reported on (and is not recommended herein, due to the known thermal stability of debromoaplysiatoxin).

The published medical literature on stinging seaweed afflictions relates largely to the dermatopathology, there being little information on the gastrointestinal effects of a toxic ingestion. One report is that of a researcher who, while working with a solution of debromoaplysiatoxin, developed tingling and burning sensations of the soft palate, fauces, tip of the tongue, and lower lip which lasted 48 hours.[13] The circumstances of the exposure, the treatment, and the histopathology of the affected areas was not described in the report. Several animal feeding tests were devised in order to test for the toxicity of lyngbya seaweeds collected from various beaches in Hawaii. In one test, white mice fed dried alga combined with standard mouse food in pellets developed conjunctivitis, became lethargic, and died within 2 days.[4] In another test, mice force-fed a fluid gelatin suspension of ground dried alga at 0.3-1.0 percent body weight developed muscular weakness, convulsions, and death within 2-3 hours.[4] A review of the literature on *Lyngbya majuscula* Gomont (*i.e. Microcoleus lyngbyaceus*) and the published medical literature has failed to reveal case reports relating to the human ingestion of this toxic seaweed.

Several species of marine algae from other phyla have produced human toxicity upon ingestion, a classic example being the ordinarily edible benthic alga of the genus *Caulerpa,* which becomes poisonous during the rainy months in the Philippines.[19-21] Upon chewing the raw dried Caulerpa, one person developed numbness of the extremities, cold sensations in the feet and fingers, rapid difficult breathing, and loss of balance, these taking hours to wear off.[19] Other toxic marine algae exist.[7, 22]

Discussion

Microcoleus lyngbyaceus (formerly known as *Lyngbya majuscula* Gomont) is a dark green olive drab finely filamentous velvety hair-like seaweed (Figure 1) with a characteristic microscopic appearance (Figure 2) whose toxic strains are responsible for producing the clinical entity known as stinging seaweed dermatitis.[1-5] Human consumption of this seaweed, toxic or otherwise, has not been previously reported. In some cultures, the diet includes edible seaweeds (*e.g.* Filipinos, Japanese, Chinese, Hawaiians). For those people inhabiting areas where this particular seaweed is endemic, there would be the risk of inadvertent consumption of this toxic seaweed. Herein is reported one case of an experienced "limu" (*i.e.* seaweed) collector who sustained a stinging seaweed oropharyngitis after attempting to consume a toxic strain of *Microcoleus lyngbyaceus* (*i.e. Lyngbya majuscula* Gomont) collected from the Waianaia Gulch coastline on the island of Hawaii. The patient briefly chewed on the seaweed and after noticing a highly unpalatable taste he removed all the seaweed from his mouth while not having swallowed any. He immediately developed a severe burning and stinging sensation in his mouth, and was able to obtain partial relief by repeatedly rinsing his mouth with water. The physi-

cian's administration of diphenhydramine, viscous lidocaine, and prednisone were not helpful; partial relief was attained only by sucking on ice cubes. Within 24 hours he developed oropharyngeal swelling, erythema, and mucosal erosions resembling a scald, although no vesicles or blisters were seen at the time. The pain remained for 72 hours and his mouth did not return to normal until 2 weeks afterward.

The patient was a reliable historian, with manifestations of oropharyngeal involvement only and a denial of swallowing any seaweed, so esophagoscopy, gastroscopy, administration of ipecac, gastric lavage, and intragastric deposition of activated charcoal were not performed. Biopsies of the oropharyngeal mucosa were not taken, so the histopathology of the lesions is not known. Bacterial cultures of the oropharynx were not taken, so the seaweed-associated bacterial flora are not known. The patient kindly submitted several samples of the toxic seaweed (Figures 1 and 2), the seaweed being consistent with *Microcoleus lyngbyaceus* (*i.e. Lyngbya majuscula* Gomont).[5, 14-15] This toxic seaweed seemed identical to toxic seaweed collected on Kailua Beach on August 23, 1980 (*N.B.*, reference samples of each retained). These findings are not surprising since all of the stinging seaweed afflictions in Hawaii to date have been attributed to *Lyngbya majuscula* Gomont (*i.e. Microcoleus lyngbyaceus*),[2-5, 10-12] and none to any of the other species of Lyngbya.

The onset of discomfort in stinging seaweed oropharyngitis (*i.e.* seconds to minutes) appears to be much more rapid than that seen in stinging seaweed dermatitis (*i.e.* a few minutes to hours),[2-3, 5] this being perhaps related to the keratinized stratum corneum retarding the infiltration of the epidermis and dermis by the lyngbya toxins for the latter. No oropharyngeal vesicles or blisters were seen in our patient; however, it is possible that these sloughed off in the time period between the first exam and the exam 24 hours later, leaving the eroded denuded patches that were seen. The duration of the stinging seaweed oropharyngitis at 14 days approximates the duration of stinging seaweed dermatitis at 10-14 days. The manifestations of our patient's stinging seaweed oropharyngitis certainly lasted longer than the 48-hour duration of the reported researcher's debromoaplysiatoxin-induced oropharyngitis.[13] Based on the noted toxicity of the seemingly minimal exposure of our patient to stinging seaweed by an incomplete ingestion we would predict that complete ingestion of highly toxic stinging seaweed will produce severe oropharyngeal, esophgeal and gastric toxicity. The mortalities observed upon force-feeding the toxic algae to mice (*i.e.* deaths in 2-3 hours post-ingestion) suggest a potential human lethality upon ingestion of stinging seaweed.

The diagnosis of stinging seaweed oropharyngitis, esophagitis, gastritis, or gastroenteritis, is established through the history and the microscopic examination of the seaweed (Figure 2). Microscopic examination of the seaweed for diagnostic purposes is recommended, since several seaweeds resemble *Lyngbya majuscula* grossly (*e.g.* the edible Hawaiian "ele ele" seaweed, *Enteromorpha prolifera*,[23, 24] is a bright green finely filamentous nontoxic seaweed which somewhat resembles *Lyngbya majuscula*[25]). Seaweed fragments for analysis may be obtained from the meal leftovers, removed under direct vision from the oropharynx, retrieved during esophagoscopy or gastroscopy, or collected from gastric lavage washings; however, unconsumed seaweed is preferable. Biopsies of mucosal lesions may be obtained; however, there are no published histopathological reports on stinging seaweed mucosal lesions for reference at present. Clinical laboratory assays for debromoaplysiatoxin and lyngbyatoxin A are not currently available.

The differential diagnosis of stinging seaweed oropharyngitis is not established, but should include infectious and chemical (*e.g.* caustics, corrosives) components.

The best treatment of stinging seaweed ingestions is not known. Our patient had an incomplete toxic ingestion which produced an oropharyngitis responsive to ice water, ice cubes, and ice cream, but not responsive to diphenhydramine, viscous lidocaine, prednisone, or hydrocortisone. Warm water and soap washes of the oropharynx were not attempted. Thorough saline irrigations are recommended for stinging seaweed oropharyngitis. Complete ingestions producing an esophagogastroenteritis may need to be treated like an ingestion of caustics or corrosives, and the toxic seaweed should be removed as completely as possible. The roles of induction of vomiting, gastric lavage, intragastric deposition of activated charcoal, mucosal coating with mineral or olive oils or milk of magnesia, and gastrotomy are uncertain in regard to stinging seaweed ingestions.

In addition to the therapeutics, much work remains regarding stinging seaweed ingestions. All toxins present need to be identified and localized within the algae. Specific antidotes for each toxin need to be discovered. The histopathology of toxic seaweed ingestions needs defining for the purposes of biopsy and autopsy reference. Educational sessions should be provided for those who harvest edible seaweeds "limu."

Conclusion

An incomplete ingestion of the stinging seaweed *Microcoleus lyngbyaceus* (formerly *Lyngbya majuscula* Gomont) resulted in an acute oropharyngitis, which resembled a scald, in one person. Gross and microscopic examination of the seaweed confirmed the diagnosis. The effective treatment consisted of the patient's repeatedly washing his oropharynx with cold water, sucking on ice cubes, and eating ice cream during the first 48

hours. Diphenhydramine, viscous xylocaine, prednisone, and hydrocortisone gave little relief. Complete recovery required two weeks, and there were no sequelae.

Preliminarily, it would appear that a complete ingestion of toxic stinging seaweed would be accompanied by severe toxicity. In cultures which include seaweed in the diet, there would be the risk of inadvertent consumption of toxic seaweed in regions where *Microcoleus lyngbyaceus* is endemic, such as Hawaii.

Acknowledgements

The authors would like to gratefully acknowledge the following: our patient — for collecting samples of the toxic seaweed for our evaluation and for permission to prepare the case report; Roy Cameron of the audiovisual department of the Queen's Medical Center, for photography, illustrations in Figures 1, 3, and 4; St. Francis Hospital Department of Pathology, for use of facilities for photomicrography; Suzanne Wells of the HMA-EMS Program, manuscript typing; William W.L. Dang, M.D., Project Director of the HMA-EMS Program, general encouragement; and the Hawaii Medical Library, assistance in the literature search.

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HAWAII MEDICAL ASSOCIATION 125TH ANNUAL
SCIENTIFIC MEETING - October 12-16, 1981
Ilikai Hotel - SPECIAL EVENTS

Oct. 11 1:00 p.m. Registration

Oct. 12 5-7 p.m. — HMA hosted cocktail reception for all registrants, exhibitors and guests. Pacific Ballroom.

Oct. 12 7 p.m. — Hawaii Thoracic Society Fireside Chat. Speaker: Roger Bone, M.D., Little Rock, Arkansas. Topic: "Adult Respiratory Distress Syndrome — New Trends"

Oct. 12 7:30-10:30 p.m. — Program on Skin Cancer and Melanoma. Sponsored by Community Cancer Program of Hawaii.

Oct. 12 & 14 — House of Delegates Meeting beginning at 1:30 p.m.

Oct. 12, 13, 14 7:30-12:00 noon. Technical and scientific exhibits.

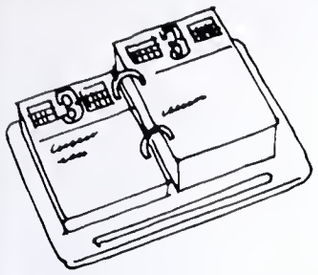
Oct. 13 HMA Annual Golf Tournament. Navy-Marine Golf Course. Shotgun start at 1:00 p.m.

Oct. 13 Sportsmen's Night Party. Hale Koa Hotel. Cocktails, dinner, awards and fun.

Oct. 16 HMA Annual Banquet and 125th Birthday Celebration. Ilikai Pacific Ballroom. Cocktails, dinner, installation of officers, awards, and entertainment.

There will also be a tennis tournament, a combined deep sea fishing and skin diving tournament, a table tennis tournament, and possibly a racquet ball tournament.

If you have any questions regarding any of the above events, please call the HMA office, 536-7702, for information.



Continuing Medical Education

CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G.N. Wilcox Memorial Hospital, First Thursday, 12:45 p.m. and Fourth Tues. 12:30 p.m. w/Maui Mem. Hsp. Held on Oahu at Am. Cancer Society main conf. room, 200 N. Vineyard, Honolulu.

John A. Burns School of Medicine

1. Dept. of Medicine
 - A. Case Conferences, Second and Fourth Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 - B. Grand Rounds, First and Third Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 - C. Endocrinology Grand Rounds, Third Wednesdays, 5:30-6:30 p.m., Queens University Tower, Room 506.
 - D. Hematology Grand Rounds, Second and Fourth Mondays, 12:30-1:30 p.m., Queens University Tower, Room 721.
 - E. Cardiology Grand Rounds, First and Third Tuesdays, 5:30-6:30 p.m., Queens University Tower, Room 508.
 - F. Infectious Disease Grand Rounds, Second and Fourth Tuesdays, 5:00-6:00 p.m., Queens Nalani I Conference Room.
 - G. Dermatology Grand Rounds, Second Wednesday, 7:30-8:30 a.m., Queens, Queen Emma Clinic.
 - H. Pulmonary Grand Rounds, Second and Fourth Thursdays, 4:30-5:30 p.m., Queens Kamehameha Auditorium.
2. Division of Nuclear Medicine
 - A. Technical aspects of Nuclear Medicine, Second Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506, 1½ credits.
 - B. Rounds, Fourth Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506.
3. Dept. of Obstetrics and Gynecology
 - A. Grand Rounds, Wednesday, 7:30-8:30 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
4. Division of Orthopaedics
 - A. Fracture Conference, Tuesdays, 5:00-6:00 p.m., Queens University Tower, Room 618.
 - B. Shriners Hospital Conference, Tuesdays, 7:15-9:15 a.m., Shriners Hospital.
5. Dept. of Pediatrics
 - A. Grand Rounds, Thursdays, 8:00-9:00 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 - B. Pediatric Conference, Mondays, 12:45-1:45 p.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 - C. Pediatric Infectious Disease Conference, Thursdays, 12:30-1:30 p.m., Kapiolani-Children's Medical Center, Third Floor Conference Room.
 - D. Neonatal Ground Rounds, Fridays, 8:00-9:00 a.m., Kapiolani-Children's Medical Center, Administrative Conference Room.
6. Dept. of Psychiatry
 - A. Grand Rounds, Fridays, 8:00-9:30 a.m., Queens University Tower, Room 618.
7. Dept. of Surgery
 - A. Grand Rounds, First, Second and Third Saturdays, 7:30-9:00 a.m., rotating hospitals.
 - B. Statistical M and M, last Saturday, 7:30-9:00 a.m., rotating hospitals.
 - C. Journal Club, First and Third Tuesdays, 6:00-8:00 p.m., Queens University Tower, Room 620.
 - D. Medical-Surgical G.I. Rounds, Second Tuesday, 7:00-8:00 a.m., Queens University Tower, Room 506.
8. Dept. of Family Practice
 - A. Conf., Wednesdays, 8:00-9:00 a.m., Kaiser 4th Floor Conf. Room.
 - B. Conf., Thursdays, 12:00-1:00 p.m., Kaiser 4th Floor Conf. Room.
9. Dept. of Physiology
 - A. Dept. Conf., Wednesday, 4:30-5:30 p.m., BioMed T-210.
10. University of Hawaii, John A. Burns School of Medicine Grand Rounds, Third Thursday, 4:30-6:00 p.m., Queen's University Tower, Room 618 or BioMed Building.
11. HI Oncology Group, one Monday a month, 12:30-1:30 p.m., The Cancer Center, 1236 Lauhala St., 4th Floor Conference Room.

Federation of Emergency Medicine-Maui

1. **Cardiology for the Emergency Physician.** Every Monday, 9:00-10:00 a.m.-Maui Memorial Hsp. Conf. Rm #1. (For spec. topics or further info. contact: Federation Office (808) 244-7629, or Dr. C.T. Mitchell, (808) 244-9056.
2. **Journal Club in Emerg. Medicine.** 2 hrs. Cat. I. MMH Conf. Rm. #1. 9:00-11:00 a.m.
 - 9/21/81 Annals in Em Med, 5/81; Abstracts in EM 6/81 - S. Burkle
 - 10/19/81 Annals in Em Med, 6/81; Abstracts in EM 7/81 - P. McCallum
 - 11/23/81 Annals in Em Med, 7/81; Abstracts in EM 8/81 - J. Mills
 - 12/221/81 Annals in Em Med, 8/81; Abstracts in EM 9/81 - C. Mitchell

Hawaii Thoracic Society

1. Pulmonary Med., Clinical case presentations & current research in pul. med. with U of H Sinclair Chest Club, Third or Fourth Wednesdays, each month, 7:30 p.m.-9:30 p.m. For further info contact: Rosemary Respicio, B.S.N. at (808) 537-5966.

Hickam Clinic

1. Clinical Correlation Conference, First Thursday, 11:00 a.m.
2. Didactic—our staff, Second Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, Third Thursday, 11:00 a.m.
4. Radiology Conference, Fourth Thursday, 11:00 a.m. (Contact Aurora Macapinlac, M.D., M.C., 449-5770)

Hilo Hospital

1. Orthopedic Conference, First Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7:00-8:00 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, Second Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, Third Friday, 12:30-1:30 p.m.
5. C.P.C., Second Friday, 12:30-1:30 p.m.
6. Visiting Professor's Program

Kaiser Hospital

1. Medicine Grand Rounds, Every Tuesday, 8:00 a.m. Pac. Aud. 1 hr. Cat. 1.
2. Tumor Board, Every Tuesday, 12:00 noon. Pac. Aud. 1 hr. Cat. 1.
3. OB/Ped. Perinatal Mortality Conference, Last Tuesday, each month. 8:00 a.m. 1 hr. Cat. 1.
4. Surg. Grand Rounds, Every Friday, 8:00 a.m. Pac. Aud. 1 hr. Cat. 1.
5. Saturday Morning Educational Conference, Every Saturday, 7:30 a.m. Pac. Aud. 1 hr. Cat. 1.

(Contact CME Dept.-Kaiser for further information)

Kapiolani-Children's Medical Center

1. Pediatric Grand Rounds, Every Thursday, 8:00-9:00 a.m. Aud.
2. Pediatric Conference, Mondays, 12:45-1:45 p.m. 2nd Floor Aud.
3. Neonatal Grand Rounds, Friday, 8:00-9:00 a.m., Conference Room B.
4. Pediatric Infectious Disease Conference, Thursdays, 12:30-1:30 p.m. 3rd Floor Conf. Rm.
5. Ob-Gyn Conference, Tuesday, 1:00-2:00 p.m., Aud.
 First—Didactic Presentation
 Second—Perinatal-Neonatal Topics
 Third—Obstetrics Topics
 Fourth—Gyn Topics
6. Tumor Board, Oncology Conference, First and Third Friday, 1:00-2:00 p.m. Aud.

Kuakini Medical Center

1. Department of Ophthalmology Mtg., First Tuesday, 12:30-1:30 p.m.
2. Department of Medicine Mtg. (Statistical), Fourth Tuesday, 1:00-2:00 p.m.
3. G.I. Conference, First Tuesday, 8:00-9:00 a.m.
4. Nephrology Conference, First Wednesday, 8:00-9:00 a.m.
5. Oncology Conference, Every Thursday, 7:30-8:30 a.m.
6. Pulmonary Conference, First Thursday, 1:00-2:00 p.m.
7. Surgical Conference, First & Second Friday, 12:45-1:45 p.m.
8. Surgical M & M Conference, Fourth Friday, 12:45-1:45 p.m.
9. Department of Medicine Evening Mtg., Second Tuesday, 5:30-7:00 p.m.
10. Visiting Professor Program
 (for further info contact CME Dept. 547-9226 as these programs may be subject to change.)

Maui Memorial Hospital

1. Thursday Conference, 7:00-8:00 a.m. Staff Dining Room.
 1st—Dept. of Medicine
 2nd—Dept. of Surgery
 3rd—Dept. of OB/GYN
 4th—Dept. of Pediatrics
 5th—Elective
2. Tumor Board, Every Monday, 12:15-1:15 p.m.—Tumor Conference Telephone Task Force—Third Tuesday, 12:15-1:15 p.m.
3. Dept. of Emergency Medicine, Third Monday, 7:00-8:00 a.m.
4. Diagnostic Radiology, Fourth Tuesday, 12:00-1:00 p.m.
5. SFH-UH Hematology Conf., Third Thursday, 12:30 p.m. Sullivan-4 Classroom.
6. SFH-UH Surgical Grand Rounds, First, Second, & Third Fridays, 7:30 a.m., Sullivan-4 Classroom.
7. Visiting Professor Programs (for further info call CME office at St. Francis).

Hawaii Ophthalmological Society

1. Monthly dinner meeting, Third Thursday of each month. Contact: Dr. A. Kunimoto, (808) 941-2208.

The Queen's Medical Center

1. ENT Conferences, First and Second Fridays, 7:30 a.m., Small Dining Room.
2. Medical Conferences, Every Friday, 8:00 a.m., Kam Auditorium.
3. Ob/Gyn Conferences, Second and Fourth Mondays, 1:00 p.m., Kam Auditorium.
4. Ophthalmology Conference, Fourth Tuesday, 5:00 p.m., Queen Emma Eye Clinic.
5. Orthopaedic Conferences, Every Wednesday, 7:00 a.m., Kam Auditorium.
6. Pathology Conferences, Every Wednesday, 7:30 a.m., Surgical Conference Room.
7. Pediatric Grand Rounds, Fourth Thursday, 12:30 p.m., Nalani 1 Conference Room.
8. Surgical Trauma Conference, Second Tuesday, 4:30 p.m., Kam Auditorium.
9. Basic Science Lectures, Every Wednesday, 7:15 a.m., Queen's University Tower, Room 618.

St. Francis Hospital

1. SFH-UH Tumor Conference, Every Monday, 7:30 a.m. Sullivan-4 Classroom.
2. SFH-UH Nephrology Conference, First Monday, 1:00 p.m. Sullivan-4 Classroom.
3. SFH-UH Endocrine Conference, Last Monday, 12:30 p.m. Sullivan-4 Classroom.
4. EENT Meeting, First Tuesday, 7:00 a.m., Sullivan-4 Classroom.
5. SFH-UH Hematology Conference, Third Thursday, 12:30 p.m. Sullivan-4 Classroom.
6. SFH-UH Surgical Grand Rounds, First, Second & Third Fridays, 7:30 a.m., Sullivan-4 Classroom.
7. Visiting Professor Programs (for further info call CME office at St. Francis).

Straub Clinic & Hospital

1. Straub Professional Seminar meets the Second Tuesday of each month, from 5:00-6:30 p.m. in the Credit Union Meeting Room (2nd Floor, Credit Union Bldg.).
2. Surgical Mortality and Morbidity Conference meets every Fourth Thursday of each month, from 7:00-8:00 a.m. in the Doctors' Dining Room.
3. Cardiac Surgery Conference meets the Third Tuesday of each month, from 4:30-5:30 p.m. in the Doctors' Dining room.
4. Department of Anesthesiology meets the Second Tuesday of each month from 7:00-8:00 p.m. in the Doctors' Dining Room.
5. Community Peripheral Vascular Conference meets the Fourth Thursday of each month from 5:00-6:30 p.m. in the Doctor's Dining Room.
6. Visiting Professor Program meets monthly from 7:00-8:00 a.m. in the Doctors' Dining Room.
7. Urology Inservice meets every other month on the Third Friday from 8:00-9:00 a.m. in the Doctors' Dining Room.
8. Neuropathology Clinical Correlation Conference meets the Third Thurday of each month from 7:30-8:30 a.m. in the Straub Morgue.
9. OB-GYN Pathology meets every Fourth Monday of each month from 12:30-1:30 p.m. in the Administration Conference Room (ACR).
10. Urologic Pathology meets every First Monday of each month from 8:00-9:00 a.m. in the Doctors' Dining Room.
11. Friday Noon Conference meets every Friday of each month from 12:30-1:30 p.m. in the Doctors' Dining Room.

*Note: All conferences are subject to change. Monthly calendar will be available upon request.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. General Medical Staff Meeting, Quarterly in January, April, July & October.
2. Clinical Review Meeting, Alternate Mondays at noon.
3. Tumor Conference, First Thursday.

Miscellaneous

HMA Maternal and Perinatal Mortality Study Committee, First Monday each month-5:30 p.m. 320 Ward Ave., S 200. Cat. 1 on hr. for hr. basis.

SPECIAL EVENTS

Aug. 29-Sept. 4, 1981	Concepts in Infertility-1981, Royal Lahaina, Maui, Stanley Friedman, The Edward Tyler Medical Clinic, 921 Westwood Blvd., LA 90024.
Sept. 20-26, 1981	Postgraduate Course on Reproductive Physiology, Endocrinology, Infertility. Am. Fertility Soc. Serono Symposium; 11 Brooks Drive, Raintree, MASS. 02184. Held: Hyatt Regency, Maui. 29 hrs.
Sept. 27-Oct. 3, 1981	Pacific Coast Obstetrical & Gynecological Mtg. Contact: Ralph Hale, M.D.; (808) 948-7457, J.A: Burns Schl. of Med., U of H. Held: Kauai Surf.
Oct. 3-9, 1981	Operative Arthroscopy. UCLA. Contact: CCECS, 2530 Dole St., Honolulu 96822, (808) 948-8244. Held on Maui.
Oct. 7-9,1981	"Current Neurology". Straub Clinic & Hsp. Held: Honolulu Art Academy Aug. 900 S. Beretania, Honolulu. Contact: Off. of Med. Admins., Straub, 888 So. King St. Honolulu, 96813; (808) 523-2311.
Oct. 10, 18, 1981	Sixth Annual international Body Imaging Conference. West Park Hosp., 22141 Roscoe Blvd., Canoga Park, CA 91304. Held: Hyatt Regency Htl, Maui. Oncology Board
Oct. 12, 16, 1981	Review, Princess Kaiulani, ACP, Dr. Thomas Hall, Community Cancer Program of Hawaii, 1236 Lauhala, Honolulu 96813 (808) 548-8422.
Oct. 12, 16, 1981	AMA Regional & Scientific Mtg/HMA Annual Mtg. Held: Ilikai Htl, Waikiki. Contact: AMA Dept. of Mtg. Serv.; 535 No. Dearborn St., Chicago, IL 606120.
Oct. 12-16, 1981	Western Dialysis & Transplant Soc. Contact: Linda Huprich, Conv. Mgr., 1181 So. Los Robles; Pasadena, CA 91106. Held: Hilton Hawaiian Village, Waikiki, Oahu.

OUT OF STATE

For information on any out-of-state programs or courses, refer to September 3, 1980, Supplement to JAMA or call the HMA Office.

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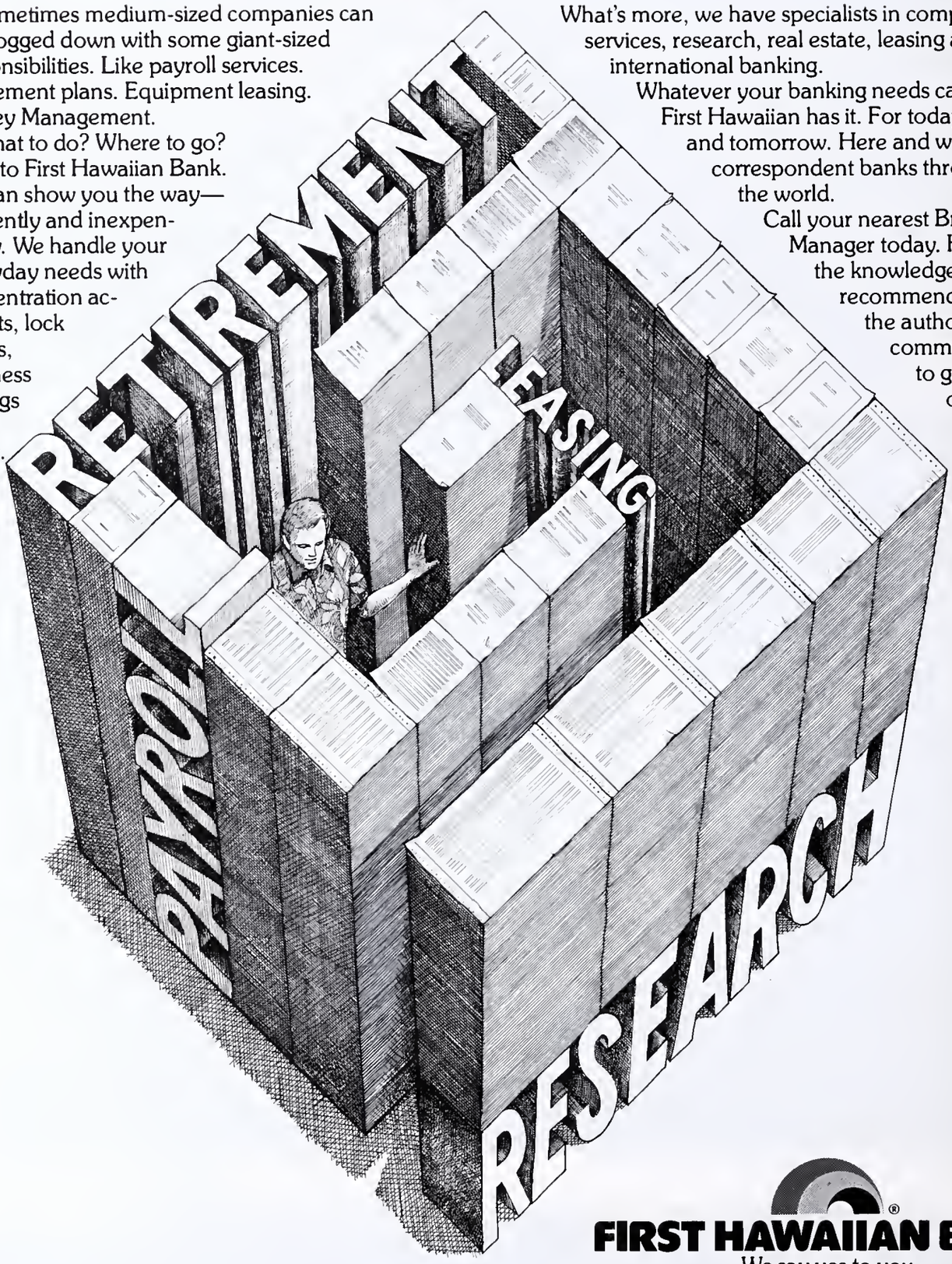
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HMA Council Meeting

Friday, May 1, 1981
320 Ward Avenue

PRESENT:

Drs. Winn, Catts, Lum, Chinn, Iaconetti, Fong, Wasson, Wentworth, Lumeng, Morgan, Shirasu, Bruce, Cahill, Wigle, Fu, Mills, Goto, Sia, Hellreich, Chang, Saiki, Dang, Howard; Messrs. V. Thomas Rice, John Edmunds, Ron Neupauer, William Scheuber, Puna Chillingworth; and Mrs. May Kim. Staff present were: Messrs. Won, Jones, Leineweber, Ajifu; Mmes. Kendro, Wong, and Chang.

CALL TO ORDER:

The meeting was called to order by President Winn at 6:00 p.m.

MINUTES:

The minutes of the previous meeting were approved as amended.

REPORT OF THE SECRETARY:

Council reviewed the Report of the Secretary as of April 30, 1981 which indicated that membership totaled 944 as compared with April 1980 when membership totaled 928.

REPORT OF THE TREASURER:

Council agreed to dispense with its review of the March financial statement. Presented for review was a listing of delinquent members whose 1981 dues and/or 1980 capital fund payments have not been received as of 4/30/81. It was noted that some delinquent members have made partial payments under the installment payment system. Council agreed that HMA send a certified letter to all delinquent members to notify them that membership will be forfeited if dues and/or capital fund payments are not remitted within 30 days from the date of the letter. Council also considered a 4/24/81 request for dues refund from Dr. Gail Li.

ACTION:

It was moved, seconded, and passed to refund the appropriate prorated portion of Dr. Gail Li's dues.

REPORTS OF COMMITTEES AND COMMISSIONS:

A. *Medical Malpractice Insurance:* Attorney John Edmunds reported on the work he has done on behalf of the Malpractice Insurance Crisis Committee. Council agreed to refer Mr. Edmunds' recommendations to the Medical Malpractice Insurance Crisis Committee for a meeting with the HMA Executive Committee for report back to Council at the next meeting. Chairman, Dr. Philip Hellreich requested Council's approval for payment of Mr. Edmunds' April 6, 1981 statement. He also pointed out that the Crisis Committee's funds fall short of the required amount by about $756.

ACTION:

It was moved, seconded, and passed to approve payment of Attorney Edmunds' statement, with HMA to make up the difference of $756.

B. *MIEC:* Council met with representatives of the Medical Insurance Exchange of California (MIEC), Messrs. Ron Neupauer, William Scheuber, and Puna Chillingworth. It was announced that MIEC has received approval from the State Insurance Commissioner to underwrite medical professional liability insurance in Hawaii. MIEC is a physician owned company which insures approximately 2,600 physicians in Northern California, Nevada, Idaho, and Alaska. MIEC's actuaries are currently reviewing Argonaut's latest filings, and it is anticipated that MIEC's Board of Governors will determine new rates to take effect on August 1. Representatives discussed the company's approach in establishing rates; in cooperating with the medical association; and in handling applications, claims, settlements, etc. HMA's assistance was requested in several areas: (1) mechanism for screening applicants, (2) peer review mechanism for evaluating possible malpractice claims, (3) establishment of administrative fee approach for availability of peer review mechanism to non-members, and (4) cover letter from HMA to inform physicians of MIEC as a viable alternative professional liability carrier.

ACTION:

It was moved, seconded, and passed that HMA request MIEC to prepare a cover letter and supporting documents for evaluation by HMA's Insurance Commission and report back to Council at an appropriate date.

C. *Interprofessional and Public Affairs: Publications:* On behalf of the Publications Committee, Dr. Doris Jasinski and James Lumeng reported that the committee had invited bids from several advertising/publishing firms to publish the Hawaii Medical Journal (HMJ). The Committee received three proposals, reviewed each proposal in detail, and personally interviewed each proposer. The Committee recommended that Council accept the proposal of Crossroads Press, to enter into contract (as outlined in the proposal from Crossroads Press) beginning August 1, 1981. In essence, Crossroads Press would become the publisher of the HMJ. They will solicit and handle all avertising, keep all advertising revenues, pay all printing expenses, provide all layout/prepublication work, and consult with HMA on editorial content upon request. HMA will retain full editorial privilege, solicit and retain all HMJ subscriptions, provide labels for mailing, and reimburse Crossroads for each copy according to a formula based upon the number of advertising pages in each issue. The Committee pointed out that annually the expenses and income should equal each other.

ACTION:

It was moved, seconded, and passed to include in the contract, a provision for HMA to establish policy regarding acceptability of advertising.

ACTION:

It was moved, seconded, and passed to approve the recommendation of the Publications Committee, as amended.

Public Affairs: Mrs. Becky Kendro reported that the Public Affairs Committee has been exploring the concept of a special newspaper tabloid for insertion in the October 11 Sunday paper to commemorate HMA's 125th anniversary. If 65% in advertising space can be sold, then 35% of the space will be allowed for text at no cost to HMA. HMA would be under no contractual obligation until two weeks before publication.

ACTION:

It was moved, seconded, and passed to pursue the concept of a newspaper tabloid.

The Committee is also considering a historical exhibit for the occasion. Council was presented with a sample of the fabric that has been exclusively designed for the anniversary. Order forms for the aloha apparel will be sent to the membership in the near future. Recently, HMA participated in judging exhibits and sponsoring 16 awards at the Hawaii Science and Engineering Fair.

D. *HAMPAC:* Dr. Leonard Howard, HAMPAC President, reported that the organization has 55 members for 1981, including 5 sustaining members. Dues are $99 of which $20 goes to AMPAC. HAMPAC's thrust this year is on membership recruitment.

E. *Legislation:* Dr. George Goto reported that 4,000 bills were introduced in the Legislature of which 300 were related to medicine. HMA provided testimony

on 55 bills. The Legislative Committee recommended: (1) that HMA consider the possibility of a part-time legislative lobbyist, and (2) that HMA, in cooperation with HAMPAC, sponsor a seminar open to all physicians on the block grant concept.

ACTION:

It was moved, seconded, and passed to explore the possibility of a part-time lobbyist.

ACTION:

It was moved, seconded, and passed to hold a seminar, open to all physicians, on the block grant concept.

F. *Public Health:* Mr. Jon Won reported that HMA submitted a proposal to the NCI for a GI/Tumor Study. PHRI decided to withdraw its participation in the submission of the proposal and instead submitted a letter in support of HMA's proposal.

G. *Health Service and Care:* Council directed the Health Manpower Committee to pursue the possibility of a cooperative study on residency training programs.

H. *Medical Services:* Dr. Thomas Cahill reported that the Medicaid Committee continues to meet with DSSH representatives to review the Medicaid Provider Manual. DSSH-Medicaid has agreed to accept the concept of using the CPT-4.

I. *Internal Affairs:* President Winn announced that Dr. Ann Catts will be appointed chairman of the reference committee at the Special Meeting of the HMA House of Delegates. Other members of the reference committee will be the four county society presidents.

J. *Jail Health Project:* Dr. Walter Chang reported that the Jail Health Project is winding down from a national standpoint as LEAA will discontinue funding as of May 30. Locally, Halawa High Security Facility has received funds to build a new building, Oahu Community Correctional Facility will have two part-time health care providers, and the DSSH Corrections Division will be conducting a study of jail health affairs for report during the next legislative session. It was Council's general feeling that HMA should continue its efforts in the area of jail health.

REPORTS OF COUNTY SOCIETY PRESIDENTS:

A. *Honolulu:* Dr. Henry Fong reported that HCMS will hold its next membership meeting on May 12 on the subject of health manpower. HCMS delegates will hold a short caucus just prior to the Special House of Delegates Meeting on May 2.

B. *Maui:* Dr. Eugene Wasson reported that Maui County held a membership meeting on April 21 with a presentation by a guest speaker on diagnostic ultrasound.

C. *Kauai:* Dr. Mark Wentworth reported that Kauai County will hold a meeting on May 5. Guest speakers will be Dr. Raymond deHay representing the Physician's Union and Mr. Ken Bugan of the AMA Membership Development Department.

OTHER BUSINESS:

A. *Auxiliary:* Mrs. May Kim briefed Council on the activities of the various county auxiliaries. Activities included AMA-ERF fund raising, fund raising for Hilo Center, and development of a HCMS Auxiliary roster.

ACTION:

It was moved, seconded, and passed that Council send a letter to Mrs. May Kim to commend her on her attendance, effort, and loyalty to the HMA and its Auxiliary.

B. *Proposed Resolution:* A proposed resolution regarding finance charges on physicians' bills was presented for Council's approval. It was recommended that the resolution be submitted to the AMA House of Delegates for consideration at its Annual Meeting.

ACTION:

It was moved, seconded, and passed to approve the resolution for submission on the AMA House of Delegates.

C. *Executive Session:* Council went into executive session at 9:15 p.m. A summary of the actions taken are on file at the HMA Office.

ADJOURNMENT:

The meeting adjoined at 12 midnight.

Special Meeting HMA Council

Friday, June 19, 1981
320 Ward Avenue

PRESENT:

Drs. Winn, Catts, Hindle, Bell, Chinn, Iaconetti, Chun-Hoon, Lumeng, Morgan, Shirasu, Goto, Cahill, Fu, Newman, Mills and Dang. Also present were Attorney Rice and Actuary Reilly. Staff present were Won, Jones, Kendro.

CALL TO ORDER:

The meeting was called to order by President Winn. It was noted that the agenda for the special meeting would be limited to the two agenda items unless Council consented to add other items to the agenda.

PRINTING COMPANY PURCHASE:

Mr. Won reviewed the experience of the formal printing service established by the HMA Council in February 1981. He noted that the first two months of operation were quite successful and the demand for services was high. Staff became aware of the sale of a printing company in their investigation for additional printing equipment. A full description of the analysis leading up to the recommendations to Council is on file in the HMA Office.

ACTION:

A motion was made to approve the purchase of the assets and assumption of known liabilities in the form of loans of the A & T Corporation for $85,000 with terms of $30,000 down on an Agreement of Sale for four years at 12% per annum. It was further moved that the acquisition of 2,000 sq. ft. of space at 320 Ward Avenue be approved for the printing operations of the new company. The motion was amended to state that there will be no dividends paid out of any net profits to the HMA until the agreement of sale is paid in full. The motion as amended was passed unanimously.

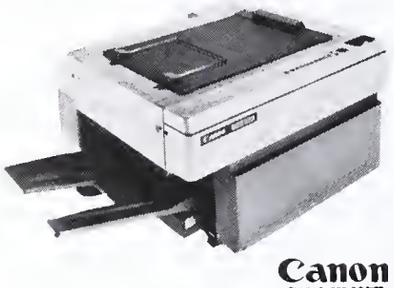
EMERGENCY MEDICAL SERVICES PROGRAM:

The Council adjourned into executive session. A summary of the actions taken are on file at the HMA Office.

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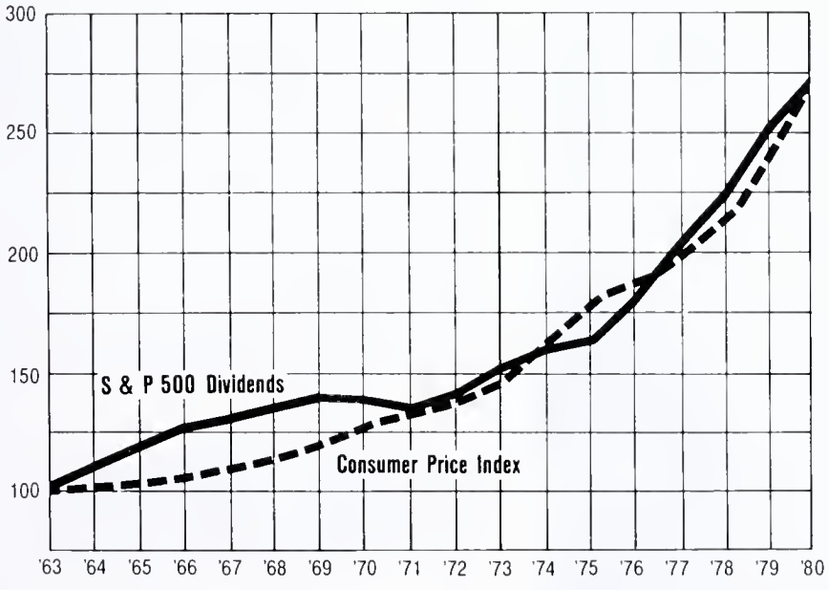
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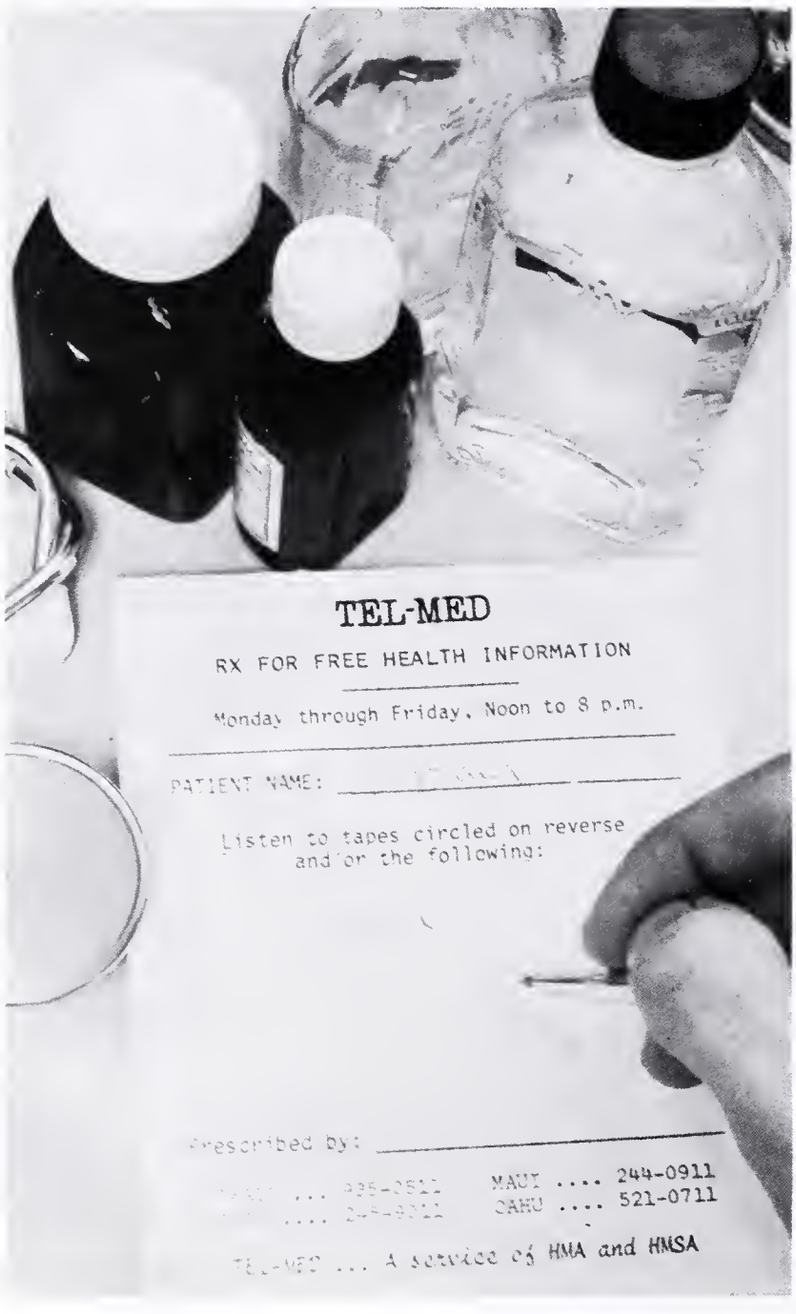


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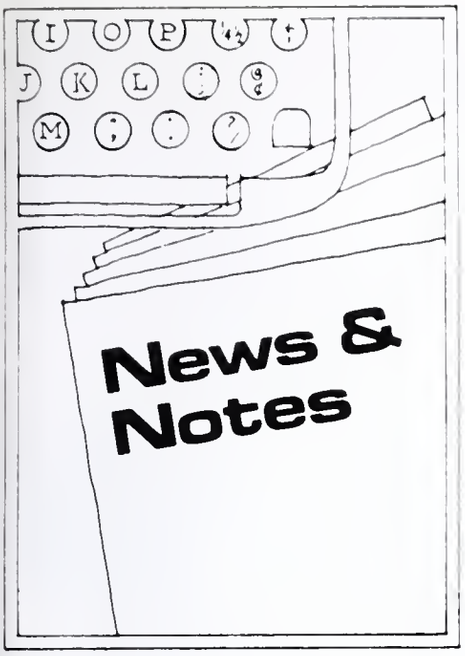
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HMA president **Neal Winn**'s letter dated May 18, 1981:

"A Letter to All Physicians in Hawaii:

The sometimes emotional and heated debates that have run for many years, both inside and outside the HMA, with regard to mandatory vs voluntary membership in the AMA, have been a most *devisive*/divisive one

This bylaws amendment, in my view, no way casts *dispersions*/aspersions upon the AMA nor does it signal, in any way, the withdrawal of support of the AMA by the HMA . . . " (Submitted by our ever alert humorist **Fred Reppun** . . .)

Hors De Combat

Neuro surgeon-lawyer **William Goebert** testified in the Jilly's Disco murder case: he had pronounced the 21-year-old Kahuanui dead and withdrew the support system with the consent of his family . . . Kahuanui had multiple skull fractures and brain matter was oozing from his left ear . . . The defense attorneys, obviously unprepared for such testimony, asked the judge to declare a mistrial or a postponement to research the medical-legal questions . . . Two of the defense attorneys wanted to withdraw from the case because they felt the whole tenor of the case had changed . . . Another defense attorney felt that **Bill Goebert**'s testimony had "implications in the charges against our clients." (Ed. Guess it takes a doctor-lawyer to tell it as it is . . .)

A recent legislation set up new rules for the use of the EMS system, i.e. Maui's ambulance service will cost $110 per ride after July 1, and that the ambulances will no longer be available for non-emergency transfers . . . The real problem is the matter of transfers between facilities since there are no private ambulances available . . . Maui Memorial chief of staff **Sakae Uehara** says, "The battle is between the EMS branch and the DOH, the county and the community." He told the medics, "It's fruitless to fight among yourselves . . . The EMS has a certain job and they shouldn't be doing more than that."

Medicaid costs have been rising at the rate of 15% per year for the past 5 years and President Reagan has proposed a 5% increase limit . . . The Senate adopted it with some changes whereas the House rejected the idea . . . The Senate declined to drop PSRO while the House adopted a longer phasing out period . . . Both chambers agreed to close the Public Health Service hospitals . . . Both chambers agreed to changes in Medicare — to save $1.2 billion to $1.6 billion in the federal budget . . . The Senate would raise the hospitalization deductible to $75 from $50 . . . The House would raise it to $70. The Senate would reduce the minimum federal contribution to Medicaid from 50% to 40% . . . Only 12 states including Hawaii would be affected. (California and New York alone accounted for one-third of all Medicaid outlays in1979.) The president feels that limiting the Medicaid payments to 5% a year would save $1 billion the first year alone and force the states to manage their programs more efficiently . . .

The Hawaii Supreme Court ruled that court-appointed psychiatrists have absolute immunity from civil charges of negligence . . . The decision affirms a 1977 ruling by Circuit Judge **Arthur Fong** who dismissed a $700,000 suit against three court-appointed psychiatrists whose recommendations allowed **Paul Luiz** to be placed on supervised release from Hawaii State Hospital shortly before he killed **Barbara Seibel.**

The demolition crew was about to start swinging the wrecking ball on the 77-year-old Alexander Young Building one week ahead of schedule. The Voice of the Pacific (a group of such stalwart souls as **Norman Goldstein, Birendra Huja** et al) had hastily prepared legal papers signed by Justice **Ben Menor** which stopped the premature demolition after five blows had been struck against the building . . . Alas, a skirmish won, but the battle lost . . .

Sportsmen . . .

Incidental intelligence: The divorce rate is 3½ times greater among joggers; esp if the wife jogs and the husband doesn't . . . The wife is more apt to run away . . . The rate is lowest when both husband and wife jog together . . .

Golf Joke (as told by **Bill Dang**): Bob, an ardent, but inept golfer was playing with his wife Sue (a lower handicapper) who kept nagging: "Honey, you should keep your head down." Bob continued to struggle and kept his cool till they came to the par 3 water hole . . . Bob topped three balls kerplunk! into the water . . . He grabbed his clubs and threw them one after another into the pond . . . Then, he jumped into the pond saying, "I can kill myself!" Sue seemed unperturbed by all this . . . Jean and Bill who were playing in the same foursome were frantic . . . "Shouldn't we go after him?" they asked . . . Sue replied, "Oh, don't worry . . . He won't keep his head down long enough to drown . . ."

Professional Moves

Homo Sapiens Medicus is a restless breed in this Year of the Cock . . . We have seen more changes in this medical community than ever before and the changes still continue.

In June, endocrinologist **David Fitz-Patrick** joined the Straub Clinic, **Herb Takaki** relocated to Suite 604, Kuakini Medical Plaza from the Young Hotel Bldg, pediatrician **V.J. Reddy** joined the Honolulu Medical Group, Inc, and gastroenterologist **Myron Lezak** opened at Suite 307, 46-005 Kawa St, Kaneohe. In Waipahu, pediatrician **Fuchat Chan** opened the Waipahu Pediatrics at the Honolulu Fed Savings Bldg, Suite 304, 94-229 Waipahu Depot Rd, Waipahu and internist **Don Nikaitani** opened at 94-873 Farrington Hwy, Waipahu. On the Big Island, psychiatrist **James Morgan** joined **George Kojak** at Kuakini Tower, Suite 107, in Kailua-Kona and in Hilo, internist **Roy Koga** opened at Hilo Plaza Bldg, 180 Kinoole, Suite 117.

In July, OB-Gyn person **Lynette Furukawa** opened at Kuakini Medical Plaza, Suite 613, dermatologist **Paul Sunahara** opened at Suite 610, Kuakini Medical Plaza and another OB-Gyn person **Elenita Alvarez-Pacpaco** relocated to Suite 510, Kuakini Medical Plaza . . . The St Francis Medical Office Bldg also had its share of new occupants when internist endocrinologist **S.Y. Tan** opened at Suite 206 and thoracic-cardiovascular surgeon **Jeffrey Lau** moved into Suite 304. Internist **Birendra Singh Huma** and GP **William Walsh** relocated to 1270 Queen Emma Street (when the demolition crews started to destroy the Young Hotel Bldg despite the furious efforts by **Norman Goldstein** et al to save it has a historic site). OB-Gyn man **Gary Kimoto** joined the OB-Gyn Associates, Inc, at 1319 Punahou St and dermatologist **Milton Ackerman** announced that he will open soon at the Atlas Insurance Bldg, Suite 201. In Hilo, **Ruth Matsuura** announced that her office at 670 Ponahawai St, Suite 214, will be known as Komohana Medical Clinic and that she and **Kathleen Ohara** will handle pediatrics, **Brian Wilson** will do pediatric and adolescent medicine and **Susan Gilbert** will do family practice. The Hilo Medical Group, Inc, announced that internist **Daniel Belcher** will join the group at 1292 Waianuenue Ave, Hilo. In Maui, ENT man **Thomas Erbach** joined The Maui Medical Group at 2180 Main St, Wailuku

Miscellany . . .

The physician golfer sliced his second shot over the hill on the Mid Pac CC 13th hole. He heard a painful yell . . . He dashed over and saw a member of the foursome ahead lying on the turf . . . The stricken fellow cautiously opened one eye which glared avariciously. "I'm a lawyer and I'm going to sue you for five thousand dollars!" "I'm sorry," apologized the golfer, "but I did yell 'Fore!' " "I'll take it," said the lawyer . . . (As told by our golfing friend, **Alan Luning**)

"The people upstairs are very annoying," complained the tenant . . . "Last night, they stomped and banged on the floor until past midnight."

"Did they wake you?" asked the landlord . . .

"No," said the tenant . . . "Fortunately, I was playing my tuba." (From Reader's Digest)

Oncology Dialogue

A 55-year-old woman had surgery for breast CA 14 years ago and now presents with linitis plastica which showed some response to an oophorectomy in December last year . . .

Pathologist **Grant Stemmerman:** "Formerly linitis plastica was associated with melanoma, but more recently it seems to also be associated with breast CA . . . "

Moderator **Glenn Kokame:** "What's the breast CA staying dormant for 14 years?"

Stemmy: "Some will say it was in G1 and others will say G2 . . . We make a plea for better histories . . . Fortunately we had enough material in deep freeze for estrogen receptor studies . . . I know we're miracle workers, but . . ."

Chemotherapist **Paul Condit** suggested, "If the oophorectomy in December showed response, she has one chance in three to expect

further response with adrenalectomy . . . "

Fellow oncologist **Noboru Oishi:** "There are some recent reports that medical adrenalectomy is just as good as surgical adrenalectomies . . . "

Stemmy with an impish grin: "Why not give everything at once instead . . . Tamoxifen and all the mixtures of poisons you have . . . "

Oncologist **Kevin Loh** seemed to concur: "You are right . . . There is data from Oklahoma that suggests combined adjuvant therapy results in longer disease-free intervals."

Purist **Noboru Oishi** disagreed: "I'm sorry to hear Stemmy even suggest anything so rash . . . "

Radiolotherapist **Carl Boyer** was in rare form: "We are speaking of adjuvant therapy for disease-free intervals . . . If this lady had been given adjuvant therapy 14 years ago —what a statistic she could have been . . . "

Moderator Glenn asked, "Some people are doing oophorectomy and adrenalectomy at the same time . . . What do you think, Roy?"

Surgeon **Roy Iritani:** "Sequential surgery is better . . . "

Carl Boyer: "I think we should stop talking because it is getting ridiculous . . . "

Glenn: "Amen . . . "

A 45-year-old Filipino woman was worked up for a Lt facial twitch, Lt hemiparesis and Lt hemiparesthesia. Blood flow and brain scans showed multiple focal lesions in both hemispheres. Chest X-rays revealed a 5 cm mass in the RLL. Bronchoscopy failed to get a specimen but a percutaneous biopsy of the mass showed adenocracinoma.

Moderator Kokame asked, "Did she have an upper GI and BE?"

Carl Boyer responded dogmatically: "They will be negative."

Glenn remarked, "If Carl says an elephant, it is an elephant."

Computer-brained **Kevin Loh** gave the following grim statistics: "In solitary brain metastases from lung and breast CA's, surgery and radiation give a 9½ months survival whereas radiation alone would give a 3 months survival . . . "

Miscellany . . .

The Elephant and the Ant Joke: The elephant and the ant made violent love all night . . . In the morning the ant found the elephant dead . . . "Jesus!" says the ant . . . "One night of passion and I have to spend the rest of my life digging his grave." (From Hillstreet Blues)

"An archeologist is the best husband any woman can have . . . The older she gets, the more he is interested in her." (From Lou Boyd's column)

Elected, Appointed Honored

Calvin Sia, pediatrician, past HMA president and an active member of various community programs related to child care, health and family, was chosen by the Dartmouth College Class of 1980 for its "Outstanding Contributions to Society Award." Cal was honored for his role in promoting legislation on mandatory immunizations for children, mandatory reporting of child abuse and neglect, and establishing school health services programs . . .

Robert Nordyke, chief of Straub's nuclear med department, has been elected governor of the Hawaii chapter of the American College of Physicians . . . **George Shimomura** has been elected chief of staff of Kapiolani Hospital for a two-year period and **Gary Fujimoto** has been elected assistant chief of staff replacing **Murray Berger** and **F.C. Li,** respectively . . . **F.C. Li, Ronald Berman** and **Dorrell Waxman** were elected to the hospital medical executive committee.

The following physicians were sworn in recently in ceremonies held in the governor's office: **Fred Evora** appointed to the Medical Advisory Board and **Julia Frohlich** to the U of H Board of Regents.

Life in These Parts . . .

DOTSON DELIVERS IN A TOYOTA! On Kauai, **Larry Dotson,** OB man delivered a 9 lb 11 oz baby in a Toyota truck parked in front of the Kalaheo fire station . . . The delivery wasn't as sterile or as private as it might have been but the "audience" was enthusiastic and everything went well . . . (From the Garden Isle . . .)

"Latest 'only in Hawaii' ailment — a skin rash that affects the stomach and chest which physician **Alan Nelsen** calls " 'boogie-board rash.' " (Dave Donnelly's Hawaii)

The overall cost of care in Hawaii hospitals was 15% higher in the first quarter of 1981 than last year. The hospitals' Voluntary Cost Containment Committee showed data that major factors in the increased cost of health care were rising bills for utilities, up 62% from 1980; interest, up 51%; food, drugs and supplies up 15%; and salaries, up 13% . . . **Tom Battisto**, acting chairman reported that the hospitals are encouraging outpatient facility use rather than admit patients in an effort to keep costs under control. There were 18% more outpatient visits this year than last. The hospital committee also warned that patients are being forced to foot the bill for such losses as: bad debts; free or reduced cost medical care given by hospitals in order to qualify for "Hill Burton" assistance; Medicare and Medicaid services to the poor and elderly which are not fully compensated because of low government payment schedules . . . **Paul Cook,** public relations chairman for the committee, calls the growing losses from these sources "a serious threat to the viability of Hawaii's hospitals." The net loss to Hawaii hospitals from these sources was $8.7 million in the first quarter of 1981, more than double the total of just three years earlier . . .

Florence Nightingale must be turning over in her grave . . . When a shortage of nurses forced at least two Honolulu hospitals — Kaiser and Queen's — to close some wards and delay non-emergency surgery, **Pat Osgood**, director of nursing practice for the Hawaii Nursing Association, blamed the shortage on low salaries and Hawaii's high cost of living. Nurses with two years' experience are paid $8.81 per hour here while on the mainland they are paid $10 to $12 per hour. **Ronald Mikolajczyk,** Kaiser hospital administrator, said, "Nationwide, fewer women are becoming nurses and fewer want to work in Hawaii because of the high cost of living. To many, the nursing profession has perhaps become less attractive because of a lack of recognition and because the growing amount of paperwork and medical technology leave less time for 'hand-on' care."

Oliver Hasselblad, 71, medical administrator of Kalaupapa has been involved in leprosy work and research throughout the world for more than 40 years. He says, "Leprosy can mimic almost any skin disease and sometimes

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isn't properly diagnosed." Oliver has been conducting 3-hour illustrated lectures and workshops on diagnostic techniques to reawaken a higher degree of suspicion of the early signs of leprosy in the medical profession.

"Health Plan Hawaii" is HMSA's federally qualified HMO and six of the 15 CHP's (Community Health Program) have moved over. The difference in the new plan from the CHP are (1) a cap on the amount of co-payments required of any person or family per year ($280 for a single person and $760 for a family); (2) payment of injectable drugs; and (3) an increased co-payment for emergency room care — from $1 under the CHP to $10 under the Hawaii Health Plan. The six CHP's which have agreed to switch over are: the Maui Medical Group, the Kauai Independent Physicians' Program, the Hilo Medical Group, the Kona Medical Associates, Central Medical Clinic and the Fronk Clinic.

Kalua pig sold the weekend of June 20 by two Windward organizations, the Flamingo Street Preschool and the Lanikai Canoe Club, caused food poisoning from Salmonellosis in at least nine persons, two of whom were hospitalized. Thirteen other suspected cases of Salmonellosis were being investigated by the Health Department. Tests on 15 samples showed salmonella in 9 . . .

The long awaited "911" emergency number finally became available to Kauai residents on July 1 . . . It took two years and $70,000 in federal funding and an additional $30,000 for hiring two more dispatchers . . . but things do move slowly on Kauai, it seems . . .

Kauai residents will definitely be shocked to find out that the state will also start ambulance service on its North Shore on July 1 . . . **J.K. Sims**, chief of EMS, reports that the North Shore unit will be housed in Princeville staff housing and will be manned by emergency medical technicians rather than paramedics.

The Governor has released funds for the renovation and expansion of Hana Medical Clinic. The original funding request for $40,000 was cut into $20,000, but half is better than none. Clinic director **Milton Howell** says the funds will be used to expand the medical building by two examining rooms and an administration office . . .

New Orleans May Never Be the Same

The Aloha Jesters, a local jazz band with neurosurgeon **Ralph Cloward** on E-flat saxophone and the hot stick (clarinet), pediatrician **George Ewing** on bass and including a retired general, a retired bank VP, a retired CPA, an architect, a retired furniture company president etc were bound for New Orleans, the jazz capital of the world. "Clarinetist-neurosurgeon Cloward is especially effective on the hot stick as he weaves a counterpoint to trumpeter Kruswick (an engineer, on lead trumpet). (From Bob Krauss's column)

The State Legislature two years ago gave the State DOH responsibility for providing ambulance services in all four counties. On Kauai and Maui, a private ambulance firm was hired. On Oahu and the Big Island, the county governments were given the contracts. But all was not well . . . The City asked $4.6 million reimbursement for services provided July 1980 to June 1981 and it turned out that the State had only budgeted $3.7 million. For the coming fiscal year, the City was asking $5.1 million, but the State could only guarantee $4.5 million, leaving a $600,000 shortfall to negotiate. The City Council, fed up with what they consider

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constant haggling with the State, voted to turn over operations of Honolulu's ambulance service "lock, stock and barrel," to the State DOH . . . The transfer was to take place within 90 days . . . But the fault for the deficit seems to be the City's . . . Both **Lawrence Koseki**, the City's deputy managing director, and **Elizabeth Anderson**, director of the Medical Health Services Division of DOH, say that the City's previous administration simply didn't give the State the right figures to plug into the State's biennial budget. **Anna Maria Brault**, director of the City Health Dept, received the decision "with a sense of destiny . . . It isn't who runs the program, but how well it is run . . . The City has done a fantastic job in improving ambulance services . . . " Anna didn't foresee any problems in transferring the ambulance operations to the State . . . But the State's **Elizabeth Anderson** and EMS chief **J.K. Sims** weren't quite so optimistic. Sims said, "It's a huge undertaking . . . It's too short notice for a state system . . . " Anderson said it would have been "in the best interests of the people if the county continued to operate the program . . . We have been very satisfied with the emergency medical services provided by the City and County . . ."

Dennis Meyer, QMC director of medical education, was concerned about the current and controversial form of alternative medicine called "colon therapy" and its medical complications. "America is a color-conscious society in love with its intestines . . . That's why many people go to great lengths to keep their colons clean . . . Sometimes their efforts may do more harm than good." Dennis cites three cases, including one of his own patients, who developed problems after colon therapy . . . Colon therapy involves alternately filling and emptying the colon with water and oxygen as practiced by two colon clinics on Oahu as well as in private homes . . . **Gary Van Epps**, administrator of the Honolulu Colonic Center, says the medical profession "just doesn't understand colon therapy." One patient even got relief from an arthritic condition, "but we don't guarantee that colon therapy is going to cure anyone of anything." Everyone should consider colon therapy because without the therapy there may be a "buildup of residual waste matter in the colon." Van Epps refers the patient to his family physician or to Dr **Margaret Rose** who gives the patient a complete physical exam and if necessary, a barium enema to determine any colon problems. Margaret who screens the patients referred to her admits the therapy is controversial, but "I've seen people who feel so much better after colon therapy." **Dennis Meyer** says, "To say toxins buildup is crazy, unless, of course, the liver is not working properly . . . People going to colonic clinics have intestinal complications . . . Filling up the intestines without a good medical evaluation is fraught with potential catastrophe."

Conference Notes . . .

Jan Isenberg, prof of medicine, UC, San Diego lectured on Peptic Ulcer Therapy at a QMC Friday morning conference in April . . .

"Cimetidine is ahead of Valium as the No 1 drug used in the U.S. . . . The incidence of duodenal ulcer hit its peak in the 1950's and has declined considerably since . . . re Smoking and Ulcers: (a) Cigarette smokers have a two-fold greater incidence than non-smokers . . . (b) Dose response: related to number of cigarettes per day; the number of packs per year; whether one inhales or not; (c) Mortality and morbidity of ulcers is greater in smokers than non-smokers . . .

re Aspirin and Ulcers: No difference between buffered and regular aspirin . . .

	Regular	Buffered	Enteric Coated
Erythema	24/30	13/16	25/36
Erosions	23/30	11/16	9/36
Ulceration	7/30	5/16	2/36

re Pathophysiology of Aspirin: 2 effects

1. Topical effect — damages gastric mucosa barrier to H+ions

2. When absorbed in blood stream, inhibits prostaglandin synthesis (Prostaglandin has protective effect on stomach). Indomethacin and Motrin also inhibit prostaglandin synthesis . . .

re Corticosteroids:

1. Produces ulcers or exacerbates ulcers when (a) Used longer than 30 days; (b) Total dose is greater than 1,000 mg prednisone; (c) Patient has prior history of ulcer . . .

2. Does not cause ulcers when (a) ACTH used; (b) Total dose is less than 1,000 mg prednisone

3. Not associated with UGI hemorrhage . . .

re Diet Therapy:

1. No evidence that bland diet alters ulcer symptoms, healing rates recurrence or complications . . .

2. Milk is a potent stimulant of acid secretion . . .

3. No evidence that avoiding spices, fruit juices, coffee and alcohol promote ulcer healing . . .

4. Nocturnal pain is a/c food ingestion before sleep . . . Use Antacid or Cimetadine 300 mg hs to prevent . . .

re Total Acid Output:
"Decaffeinated coffee is a potent stimulant of acid production"

Water:	< 10
Smoking:	20
Coke:	20
7-Up:	> 20
Tea:	> 20
Coffee:	30
Tab:	30
Kava:	< 30
Beer:	35
Milk:	40

re Antacid in DU Rx: Duodenal ulcer patients need strong antacids . . .

	Healed	Not Healed
Antacid	78%	22%
Placebo	45%	55%

re Drugs:

Ranitidine: No side effects; 5-6 times more potent than Cimetidine; cheaper.

Cimetidine: Less than 5% side effects.

Side effects include gynecomastia, decreased sperm count, decreased liver function, prostatic hypertrophy.

Use only in acute episodes of DU . . .

400 mg Cimetidine hs: no recurrence for 52 weeks whereas recurrence within 13 weeks with placebo . . .

Conference Notes . . .

PROLACTIN & GALACTORRHEA (Lecture by endocrinologist **S.Y. Tan** at Kam Auditorium 6-25-81)

A. *Prolactin:* pituitary hormone which can be used in the evaluation of infertility etc . . .There are a large number of hypothalamic factors which influence prolactin secretion . . . Inhibitory factors exert dominant control over prolactin secretion . . . "
 1. Inhibitory factors: Prolactin Inhibitory Factor (PIF) — probably Dopamine
 2. Stimulatory Factors: Histamine, Endorphin, Melatonin, Seratonin, PRF (TRH)

B. *Galactorrhea:*
 (a) Idiopathic: (with or without menses) (Single commonest cause)
 (b) Pituitary tumor (1 in 5)
 (c) Other Causes of Galactorrhea:
 (1) Drugs . . . 3 P's (Phenothiazines, Pressure pills, and "Pill")
 (2) Hypothryoidism
 (3) Renal Failure
 (4) Ectopic production by tumor
 (5) Hypothalamic disorder with de creased PIF
 (6) Prolactin secreting pituitary tumors
 (7) Empty Sella syndrome
 (d) Ddx Tumor and Non-Tumor:
 1. Anatomical evaluation of sella turcica
 2. TRH (Thyrotropin Releasing Hormone) Administration: Rise in Prolactin suggests functional galactorrhea . . . Pituitary tumor usually poorly responsive to TRH
 3. Biochemical evaluation
 (e) Treatment of Pituitary Tumor (Hyperprolactnemia)
 1. Transphenoidal surgery . . . dissecting microscope . . . microadenoma
 2. Medical: a. Bromocriptine (Parlodel): Dopamine agonist; Structural formula resembles LSD; Induces pregnancy (fertility drug); Rx for Idiopathic galactorrhea without tumor; Decreases microadenoma size . . . "Fascinating!"
 (f) Pituitary Tumors . . . Incidence of microadenomas and abnormal sella tomograms in random autopsy series: 27% microadenomas . . . therefore common occurrence without clinical symptoms
 (g) Hyperprolectinemia: Decreased bone density; hypoestrogenemia; hypoprogestinemia; decreased release of gonadotropins . . .
 (h) Bromocriptine Rx in 226 pts with GAS: (hyperprolectinemia without pituitary tumors) 80% had restoration of menses and improvement within 6 weeks
 (i) Bromocriptine Rx for Secondary Amenorrhea: 2.5mg bid effective
 (j) Amenorrhea Studies:
 90 pts with 2° amenorrhea
 32% with hyperprolectinmeia
 11 pts with pituitary tumors
 (k) Prolactin levels:
 Decreased with Dopamine
 Increased with TRH
 Increased with Sorotonin

Tidbits for the Housewife (from Lou Boyd's column)

Not everyone realizes that bread goes stale faster in a refrigerator than out of it . . .

How to gently persuade your husband to lose weight . . . Put your teen-age son's shorts in his underwear drawer . . .

Hawaii Academy of Family Physicians' Newsletter

DON AND MARLIES FARRELL

Our chapter welcomes two new members: **Harold Boyd,** an active member, has transferred from California, lives in Kailua, and practices emergency medicine. **Steve Yasui**, a student member, is in his third year at U.H. medical school.

There seems to be renewed interest in family practice among Hawaii medical students; an informational meeting on campus is planned for the near future. Membership chairman **Lloyd Kobayashi** is in charge of arrangements and expects to sign up a number of students as members of HAFP.

In other news of members: **Doris Jasinski** has been named Managing Editor of the Hawaii Medical Journal. She has also, after a brief hiatus, resumed her medical practice at her University Ave. office. **Lily Ning** and family are traveling in Scotland this summer . . . Congratulations to **Allen Chun** on his recent marriage. Allen and his bride are living in San Francisco, and are thinking of opening a practice in a small Oregon town where Allen would be the only physician . . . **Jim** and **Margret Tsuji** are traveling to Canada to attend the meeting of family physicians in British Columbia.

The next dinner meeting is planned for September 12 at the home of **John** and **Deanne Aoki** in Kailua. The program promises to be especially interesting, with **Allen Richardson** speaking on "Arthroscopy," and a representative from HMSA discussing fee schedules for FPs, compared with other specialties. There will be time for an extended question and answer period, so your attendance and input that evening are important.

The Scientific Assembly in Las Vegas is almost upon us and we hope to see many of our members there. Take advantage, also, of the post-convention scientific congress on Kauai. It will be held at the Kauai Surf Hotel September 25-30 and is approved for 16 hrs "P" credit by AAFP.

Plans are now being finalized for the HAFP Annual Meeting and Seminar to be held at the Ilikai Hotel February 13, 1982. This seminar will offer up to 12 hrs "P" credit, and will include exhibits and auto-tutors.

The nominating committee will soon be contacting members regarding various positions to be filled on next year's Executive Council. "New" blood is needed. This could be your opportunity to have an influence on the direction our specialty will be taking in the years to come. If you are interested in being a truly "active" member of HAFP, or know of a colleague who could be, call **Jim Tsuji** or **Marlies Farrell.** If the nominating committee asks YOU to help, please say "YES."

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HMA Auxiliary

Hawaii Medical Association Auxiliary — Topics of Interest

The medical auxiliary, now in its 32nd year, welcomes this opportunity to improve communication with its members through this column.

The purposes of the medical auxiliaries are to assist their medical societies in programs to promote health and well being of people in our state. The state auxiliary strives to encourage county auxiliaries to participate in and instigate health related programs that best serve their communities.

V.I.P. Visitor — Isobel Dvorsky, AMA Auxiliary President

HMAA Council and Honolulu County board members had an unexpected treat on June 25th when they met informally at the Waialae Country Club for a luncheon with new AMAA president, Isobel Dvorsky (Mrs. Harry S.). Isobel was installed as president on June 10, 1981 at the AMAA Convention in Chicago. The Dvorskys live in San Leandro, California and are parents of three grown children, two sons and a daughter. They are also proud grandparents of a two year old little girl. Isobel served as president of her home state of California in 1974-75 and since then has served in many positions on the national board. A lady of great charm, and possessing the unbeatable combination of beauty and brains, her visit served as a catalyst to spur us on in our endeavors in Hawaii.



Dvorsky

Convention Highlights — HMAA and AHCMS Annual Meeting

The annual meeting of the HMAA and AHCMS was held at the Hyatt Regency in Waikiki on May 12, 1981. The following officers were elected and installed:

HMAA Officers:

President Gwen Fu (Mrs. Denis)
President-Elect Carol McNamee (Mrs. Philip)
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Neighbor island county officers are installed in their home counties, usually coinciding with the calendar year. Currently serving as presidents of their county auxiliaries are:

Hawaii JoAnn Lundborg (Mrs. Richard)
Kauai Mary Kim (Mrs. Peter)
Maui Edith Don (Mrs. Andrew)

Affirmative Decision to Restructure

At its annual convention on May 12th the HMA Auxiliary voted to restructure the organization based on a "Council of Auxiliaries" concept. The HMAA Council will be comprised of five members, the presidents of each county auxiliary and a holdover member who will act as president. The four county presidents will each serve as an officer and the council will meet four times a year, once on each island. By holding its meetings in each of the four counties, it is hoped that the council will become better informed about the activities of the component auxiliaries and better acquainted with members throughout the state. The new system will go into effect in May 1982.

AMA Voluntary Membership

Convention delegates voted to terminate the auxiliary's "unit rule." Beginning in 1982 membership in the AMA Auxiliary will be voluntary although membership in the county and state auxiliaries (at a greatly reduced financial level) will continue to be automatic for spouses of HMA and HCMS members.

Coming Up!

Auxiliary to the Honolulu County Medical Society
Annual Guest Day — November 5, 1981
Ala Moana Hotel — Hibiscus Ballroom
Topic: Ethno-Medicine:
Crossing Cultures
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Watch for more details in next month's column.

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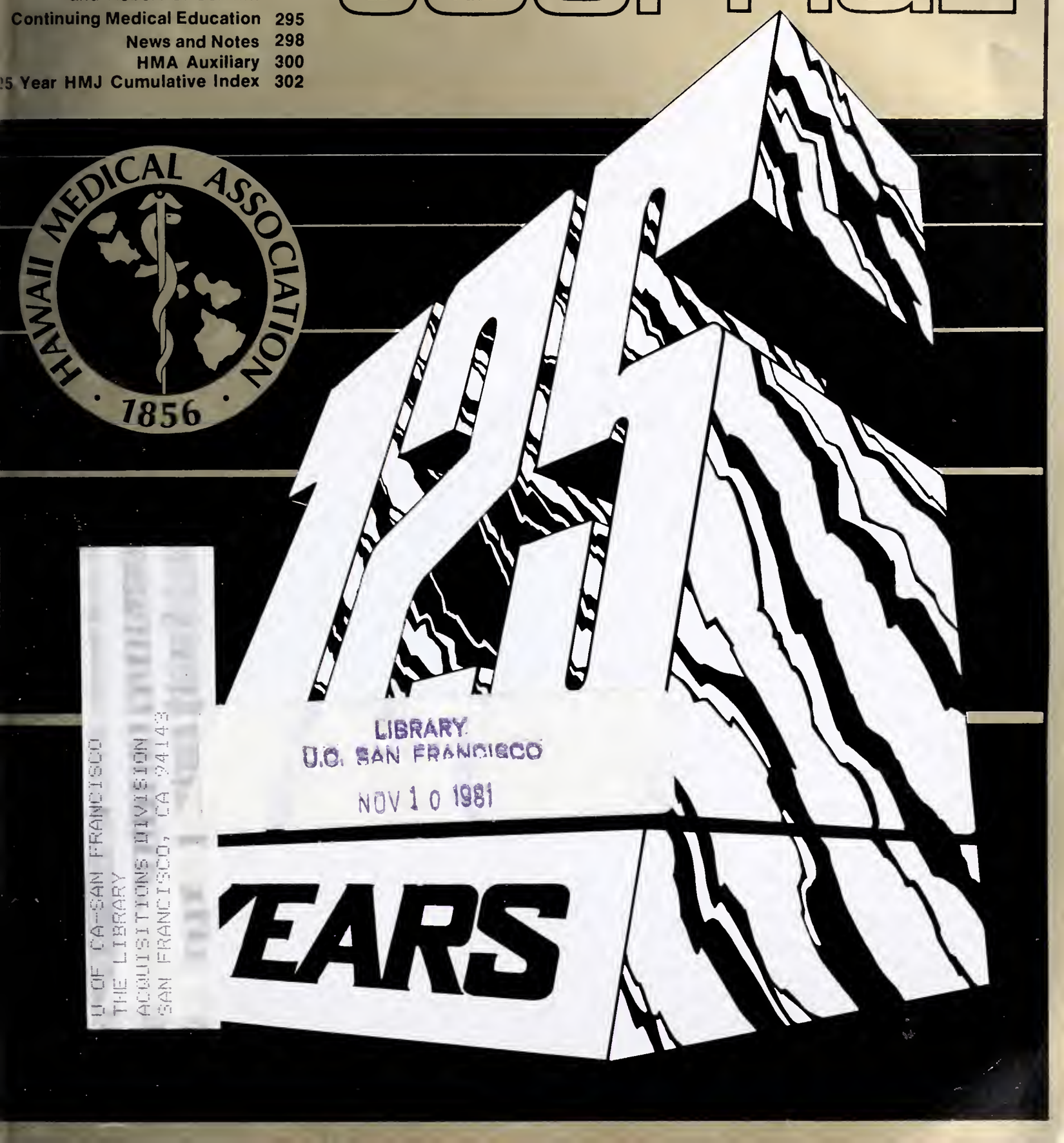
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References: 1. Data on file, Hoffmann-La Roche Inc. 2. Seppala T, *et al: Br J Pharmacol* 3:831-841, 1976. 3. Harry TVA, Richards DJ: *Br J Clin Pract* 26: 371-373, 1972.

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Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea, have resuscitative facilities available When used with narcotic analgesic eliminate or reduce narcotic dosage at least ⅓, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status. Not recommended for OB use
Efficacy/safety not established in neonates (age 30 days or less), prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.
Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam/Roche), *i.e.*, phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated)
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INJECTABLE: Although promptly controlled, seizures may return; re-administer if necessary; not recommended for long-term maintenance therapy Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated
Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug.
Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, have been observed in patients during and after Valium (diazepam/Roche) therapy and are of no known significance.
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Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure, employ general supportive measures, I.V fluids, adequate airway Use levarterenol or metaraminol for hypotension. Dialysis is of limited value.

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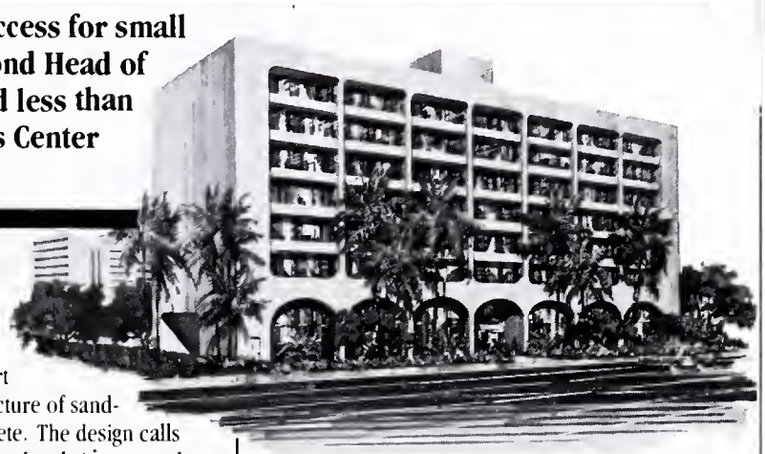
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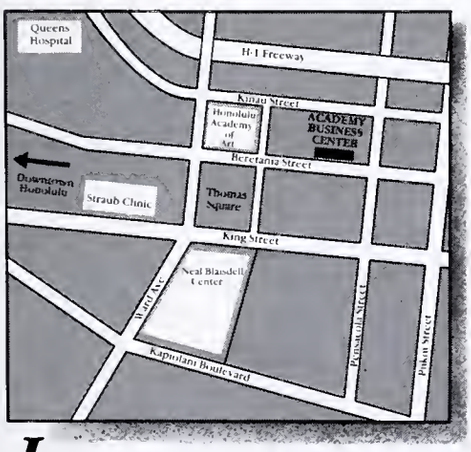


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The Hawaii Medical Association Through the Years

The Hawaii Medical Society, the first organization of physicians in Hawaii, received its charter from King Kamehameha IV on July 19, 1856. Its purpose was "devoted to the collection and diffusion of medical knowledge, the advancement of the interests and usefulness of the medical profession, and the cultivation of harmony and good feeling among its members."

Dr. R.W. Wood was the first president, and Dr. Wilhelm Hillebrand, vice-president. The original charter, duly amended, still serves the Hawaii Medical Association.

In 1895, under the leadership of Dr. John S. McGrew, a revised organization, the Medical Association of Hawaii, adopted the Code of Ethics of the American Medical Association, and required that all members be graduates of chartered medical colleges recognized by the AMA. This occurred before Hawaii was annexed to the United States.

Recommendations to the Hawaii legislature by the Medical Association of Hawaii in 1913 concerned vaccination, the sale of poisonous drugs, protection of mosquito fish, water supplies, school construction, amendments to the Sanitary Code, abolition of wet agriculture, ratproofing of buildings within half a mile of the waterfront, desirability of a child labor law, and civil service status for Board of Health employees.

(By way of contrast, the following items were endorsed by the Legislative Committee of the Hawaii Medical Association in 1975: immunity for medical peer review committees; treatment of minors with venereal disease, and placement of notification of their parents within the discretion of the physician; a joint underwriting arrangement to assure availability of malpractice insurance coverage; strengthening the power of the Board of Medical Examiners to administer, discipline, revoke, suspend, or limit licenses, through information received from a variety of sources, including professional peer review committees; and that evidence of continuing medical education, as determined by the Hawaii Medical Association, be submitted by physicians with the fee for renewal of license every three years.)

During World War I, hysteria provoked the Society to vote to drop all "alien enemy members" from membership. Ironically, there were no such members to drop!

In 1920, members were assessed to finance book and journal purchases for a medical library.

At the meeting of the HMA of April 1925, Mr. Alexander Hume Ford proposed a plan for a Pan-Pacific Science Congress. This culminated eventually in the Pan-Pacific Surgical Association, which meets every three years in Honolulu, and now has a membership of more than 2,000 surgeons from countries bordering the Pacific Ocean.

In 1925, the Honolulu County Medical Society was organized as a group separate from the Hawaii Territorial Medical Association. Subsequently, County Societies were formed on the other Islands, as well.

For a time, the Association occupied a building on the grounds of the Iolani Palace. In 1916, it moved to The Queen's Hospital, and in 1940, located in the Mabel L. Smythe Building on The Queen's Hospital grounds. Then, in August 1976, the HMA and HCMS moved to our present location at 320 Ward Avenue, in a building purchased by the HMA.

The Honolulu County Medical Society was instrumental during World War II in forming a preparedness committee to organize a city-wide system of first aid stations. This activity persists in the present Disaster Committee.

Subsequent activities in which the Association has been active have included the formulation of a relative value fee study and fee surveys, post-graduate lecture programs, workmen's compensation legislation, health education, peer review, maternal and perinatal mortality studies, child and school health programs, and the State Cancer Commission and Hawaii Tumor Registry.

Here's to the next 125 years of the Hawaii Medical Association!

C.S. Judd/D.R.J.

Great Anniversaries!

With this issue of the recently resurrected HAWAII MEDICAL JOURNAL, we celebrate two great anniversaries: the 125th of the Hawaii Medical Association, first chartered under the Monarchy in 1856 by King Kamehameha IV, and the 40th year of publication of the HAWAII MEDICAL JOURNAL.

Much is said elsewhere in this issue about various aspects of the past 200 years of health, illness, and doctors in Hawaii.

Let us here give tribute to Dr. Harry L. Arnold Jr., first and still Editor-in-Chief of the HAWAII MEDICAL JOURNAL.

With unwavering devotion to the cause of medical press in Hawaii, Dr. Arnold has worked over the past 40 years, since that first issue in September 1941, to put this JOURNAL together and get it out to the doctors of Hawaii and other interested souls.

Harry, or Ar2, as he has designated himself on memos, has contributed much to scholarship, medicine, dermatology and medical press during his distinguished career, but those of us who have worked on the JOURNAL over the years think of him, first and foremost, as Our Editor and Mentor.

Keep up the good work, Harry! We love you and need your guidance!

D.R.J.

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Hawaiians and Medicine

GEORGE H. MILLS, M.D., Honolulu*

The study of injury and illness could be utilized as one approach for a presentation dealing with Hawaiians and medicine, since wars and accidents were much more common in early Hawaii than bacteria, viruses, and inappropriate food.

A second convenient approach would be to divide the presentation into two periods — pre-Cook and post-Cook.

A third approach would be to study the Polynesians and medicine from the time of their arrival in these Islands around 500 A.D. to the lifting of the *kapus* in 1819, followed by the post-kapu era.

In this presentation, I will provide a chronological sketch of the development and progression of health care from the time of Cook's arrival to the 1900s. I will identify the impact of new religion, economics, and politics that precipitated new illnesses, and the severe stress and strain of change to which the Hawaiians had to adjust.

Dr. Bushnell has described the *kahuna lapa'au*, one of the most important individuals in pre-Cook Hawaiian culture.

Captain Cook Arrives

On Sunday, January 18, 1778, Captain James Cook's ships, Resolution and Discovery, sailed past Waialua and Waianae on Oahu and dropped anchor at night off Waimea, Kauai. It is said he accidentially ran into the Hawaiian Islands and, in doing so, he broke 500 years of isolation of these Islands from the rest of the world. He and his crew were the first white men to visit Hawaii.

In his journal he wrote:

> "The order not to permit the crews of the boats to go on shore was issued that I might do everything in my power to prevent the importation of a fatal disease into this Island which I knew some of my men labored under and which, unfortunately, had been already communicated to other Islands in these seas."

This order could be looked upon as the first act embodying concepts of western medicine and preventive medicine in Hawaii.

However, subsequent action by the crew could be looked upon as the first violation of a public health order in Hawaii. Cook's orders were pertinent but poorly enforced. Consequently, during their short stay at Kauai, accounts indicate the first introduction of western disease in Hawaii. Cook left the flea, syphillis, and other venereal diseases on Kauai. He then left Kauai, sailing to the northwest through the Bering Strait, returning to Hawaii without finding the northern passage to the East, for which he had been searching as the emissary of the Royal Scientific Society of London.

Kalaniopuu, High Chief of Hawaii, now held the northeast end of Maui after one of many battles with Kahekili, High Chief of Maui. Kalaniopuu dispatched several canoes to the visiting ships. Some claim that Kalaniopuu was already concerned about the problems of the new diseases reported from Kauai.

Off-Shore Health Inspection

The boarding party is believed to be the first off-shore health inspection conducted in Hawaii. Kamehameha, a young but already highly skilled and respected warrior, was a member of Kalaniopuu's boarding party.

After two days at Wailua, Cook sailed away from Maui down the northeast coast of Hawaii around Kalae (southpoint) to Kealakekua.

In the 40 years, 1779-1819, following Cook's visit, explorers, whalers, traders, and deserters all contributed to the insult on the Hawaiians. Don Francisco De Paula Y. Marin, the Spanish immigrant who became physician to Kamehameha I, estimated that, by 1819, disease, war, and famine had killed 150,000 Hawaiians. This was one-half the entire population estimated by Cook in 1778.

Kamehameha I, who led the Islands for the decade before his death, died May 14, 1819. He left nine wives and 24 children that are recorded.

When he was 5 years old, Liholiho, Kamehameha's oldest son by Keopuolani, was identified by him as successor to the kingdom. On May 21, 1819, Liholiho, age 22 years, assumed the responsibility as Kamehameha II.

Kaahumanu, Kamehameha I's favorite and most powerful wife, supported Kamehameha II and became his regent and chief counselor. Kaahumanu was childless.

Kapu Broken

A few months after Kamehameha's death, encouraged by Kaahumanu, Liholiho, with his mother, Keopuolani, sat and ate with the women at a huge feast. The food kapu was broken. Women could now sit and partake with men of the food which had been *kapu*. There was mixed reaction to this change. Some were jubilant; others very angry.

This change may not have been as severe as one would think, for, as an example, in the past, food kapus for women had been lifted for a few days or weeks, following the death of a ruling chief. A few months later, as part of

* Presented at the 21st Annual Convention of the Association of Hawaiian Civic Clubs held at Wailua, Kauai, 1980.

the continued rejection and the effort for emancipation from these strict *kapus*, the temples *(heiaus)* were destroyed, the *kahunas* were driven from the *heiaus*, and their power to declare *kapus* and make offerings was gone.

The Hawaiians had lost the source of their exacting discipline — many experienced mental and spiritual bewilderment.

On April 4, 1820, after a trip of 164 days and 20,000 miles, the Thaddeus arrived at Kailua-Kona with the first company of missionaries, which included the first resident medical doctor, Thomas Holman, and his wife.

The missionaries had been instructed before they left Boston that theirs was a mission of mercy, a labor of love. They were to abstain from interfering with local political interests, and they were to inculcate duties of justice.

First Missionary Physician

On April 24, 1823, three years after the arrival of the first company, the second company of missionaries arrived and included a doctor, Abraham Blatchley. Dr. Blatchley was sensitive to the devastation caused by smallpox in the rest of the world, and, soon after his arrival, tried in vain to obtain vaccine from London's inoculation hospital, the only source in the world.

Dr. Blatchley's request could not be filled. Distance placed London one to two years travel time away from Hawaii and as yet sterile containers had not been developed to keep the vaccine pure and uncontaminated.

In 1823, Kamehameha II and his wife, Kamamalu, left Hawaii for a trip to England. The king and queen and several of their party contracted measles. Kamamalu died in London on July 8, 1924, and Kamehameha II died five days later. Londoners questioned why such robust natives should die from measles and yet the frail, debilitated London females could survive.

Kamehameha III, Kauikeaouli, brother of Kamehameha II, assumed the role of king. He was 11 years old, and was to reign the longest of any Hawaiian monarch, from 1824 to 1854.

Gerrit Judd and the Mosquito

In 1828, Dr. Gerrit Parmele Judd arrived with the third company of missionaries. Shortly after arriving, he was asked to go to Lahaina to look at a strange new "itch" that was spreading among the people. He examined the rash and concluded that it was the result of the bite of the night mosquito. Further study revealed that this mosquito was now a resident of Hawaii since crewmen from the ship, Wellington, had emptied and cleaned their water barrels, which were found to contain mosquito wigglers.

Over the years we have been fortunate in Hawaii not to have malaria. There has never been a sufficient number of malaria mosquitos or enough people carrying the organism to make this a public health problem. However, we do have the anopholine mosquito and the malarial plasmodium. This means that, all conditions being right, we do have the potential for malaria.

In May 1831, Kaahumanu, at 58 years of age, expired at her home in Manoa Valley. She was certainly one of the most powerful and influential Hawaiians during the period from the time of Captain Cook's arrival to present-day Hawaii. Subsequent to her death, Hawaiian history reveals the immediate impact of the loss of her direction.

A report in the year 1836 indicated that imported diseases continued to take their toll. In the total population of the Islands, we had 107,954 residents — Hawaiians, 107,354; non-Hawaiians, 600. Of the total number of Hawaiians estimated by Cook in 1778, 60 years later, we now have 35 percent left.

The Yellow Flag

On August 1, 1836, a document directed to the Honolulu Harbor Pilot, signed by Kinau and Auhea, wives of the late Kamehameha II, and Paki, his father-in-law, directed the following:

> "You are hereby directed, previous to boarding any vessel from the northwest coast of America, and other vessels generally, to ascertain whether there has been any case of smallpox or other pestilent disease, on board such vessel for the previous 42 days. If there should have been, you are hereby forbidden to go on board such vessel, or to suffer any of your boats' crew to go on board, but to conduct such vessel to a convenient anchorage, and direct the master to hoist a yellow flag (with which you will be furnished by us), at the main, and immediately give information to the constituted authorities."
>
> "Any person neglecting these regulations will be severely punished. And vessels not conforming to the above, shall be driven from our shores."

On February 17, 1837, less than a year later, the ship, Quixote, arrived in the port of Honolulu and was identified as the source of a severe mumps epidemic that lasted through 1839. Although the disease was debilitating and incapacitating, very few died. However, on April 4, 1839, this disease took the life of Premier Elizabeth Kinau at age 35.

High Infant Mortality

By 1838, there was growing concern about the high infant mortality rate. It was pointed out that half of the infants died under 2 years of age — most between 6 and 12 months. Very few who survived the first two years died in early childhood. Causes of death have been attributed at this point to poor clothing, improper food, dropsy, and diarrhea. An example for this concern was the report of a woman who was delivered of 21 children and only one remained alive.

Early writings likewise point out that Hawaiians practiced infanticide for multiple reasons. This certainly contributed to the infant mortality rate.

On May 29, 1839, by royal proclamation, Kamehameha III ordered the governors of all the Islands to appoint boards of health. These were instructed to inspect all incoming ships since it was discovered that smallpox was present on those incoming ships, and the document signed by Kinau and Paki in 1836 was not being enforced. Although this was a major step in the right direction, these boards of health functioned poorly and were not funded.

An interesting medical report during this year revealed that Amos Starr Cook of the royal chiefs' children's school was on a trip to Waialua, Oahu, when he fell from his horse and dislocated his shoulder. After several bleedings, the first which caused him to faint, and 3½ hours of

pulling by Dr. Judd and his assistants, the dislocation was reduced. A very tired Mr. Cook, 12 hours later, was carried back to Honolulu, having a great deal of pain.

Punahou School was founded in 1841 in lower Manoa Valley on land given to Rev. and Mrs. Bingham by Liliha, wife of Boki, Governor of Oahu.

Breast Surgery, No Anesthesia

Kapiolani, who had defied Pele, died this year about six weeks following surgery for cancer of the breast, performed without anesthesia. (General anesthesia with ether was to be successfully performed in Boston some five years later.) This episode in Hawaiian medicine was significant, not only because surgery was performed without anesthesia, but the wound healing was described as being excellent and free of infection. Her death was attributed to erysiplas of the brain — unrelated to her cancer or surgery.

In 1845, Dr. Dwight Baldwin of Lahaina described the first case of leprosy in Hawaii, a disease we will consider in more detail later.

Of great medical and public health significance at this point was the fact that 600 whaling ships and 30,000 crew wintered in Hawaii this year of 1845. Lord knows the medical problems related to this evidence of Hawaii's hospitality.

In October 1848, the ship, Independence, entered the port of Honolulu seeking food and water to replenish their stores. They gifted Hawaii with measles and whooping cough. Reports reveal that nearly every child born that year died of the complications of two diseases, which were new to Hawaiians. This pressured Dr. T.C.B. Rooke, port physician, to enforce the regulations established in 1836 and 1839.

A census at this time now revealed a total population of the Islands of 84,165 — 82,035 Hawaiians, 558 part-Hawaiians, 1,572 non-Hawaiians. In 70 years since Cook's arrival the Hawaiian population had decreased 70 percent.

In 1849, the gold rush in California brought "gold fever" even to Hawaii. The demand for food and goods in the Islands was high. Basic foods were difficult to obtain and prices had increased tremendously. Both affected significantly the nutrition of the Hawaiians.

The Public Health Effort

By 1850, Honolulu had been designated the capital of the kingdom. Kamehameha III officially established the Department of Health during this year, thus making this unique department 130 years old. Only two years before this, the public health effort had been established as a government function in England. Five years later, in 1855, the first American department of health was established on the continent, in Louisiana.

During the '50s, health laws were established by the legislature that identified who could be licensed to practice medicine and prescribe drugs, and the Hawaii Medical Association was chartered by the King, making this association 125 years old.

In 1852, indentured Chinese laborers brought with them the habit of opium smoking. In an attempt to control the spread of the habit and to accommodate those who were already on the drug, a law was passed that provided for the licensing of three physicians — two in Honolulu and one in Lahaina — allowing them to prescribe opium. Each of the three licenses cost $2,000.

In 1856, a law was passed to license 14 kahunas. This action upset the physicians.

Smallpox Arrives

In spite of the ship inspection order of 1836, boards of health on each Island, and the establishment of a kingdom-wide department of health in February 1853, it was in this year that the first case of smallpox was diagnosed in Honolulu. The virus was introduced into Hawaii by the crew of the ship, Charles Mallory, out of Boston. By April, smallpox had spread and the epidemic was raging. On Oahu, with a population of 19,126, there were 9,082 cases and 5,748 deaths. There was no control of the disease, no nurses, and no hospitals for the ill.

Hawaii was to experience three more smallpox outbreaks — in 1861, 1873, and 1882. The last outbreak was introduced by the crews of five tramp steamers. There were 282 deaths; this in spite of the fact that early in 1854 the legislature had made smallpox vaccination mandatory.

Because of political unrest, the devastation of the smallpox epidemic, compulsory smallpox vaccination, and badgering by business because of the loss of dollars due to quarantine and port control, Dr. Judd was urged to retire from his responsibilities in the government of Kamehameha III. The "White King" was gone.

On December 15, 1854, Kamehameha III collapsed and died. His death was attributed to extreme worry in his last few years. Problems with land, taxes, disease, and local and international politics, involving France, England, and the United States, were extremely burdensome. Especially bothersome to Kamehameha was Lord Paulet's taking of Hawaii in the name of the queen of England, even though the Hawaiian Monarchy was restored shortly after by Admiral Thomas. From this resulted the service of Thanksgiving at Kawaiahao Church, where the king uttered the words which later become the motto of Hawaii — *Ua Mau Ke Ea O Ka Aina Ika Pono.*

On July 4, 1854, a statehood parade was conducted in Honolulu. A float carrying 32 girls of American parentage was followed by a young Hawaiian girl representing a potential new state.

Early in 1855, at age 21, Alexander Liholiho became the ruling monarch, Kamehameha IV. He was Christianized and sanctified at the pulpit of Kawaiahao Church. Later, on June 19, 1856, he married Emma Rooke, the adopted daughter of Dr. Thomas Rooke, an English physician residing in Honolulu. Kamehameha IV was Hawaii's first English-speaking Christian monarch.

Liholiho complained to the legislature about the high infant mortality rate, which was attributed to malnutrition and intestinal problems. He was also concerned regarding the high sterility rate among Hawaiian men and women, which was believed to be due to venereal disease. His primary concern, however, was that Hawaii had no hospital for his people.

No money came from the legislature in response to his plea for a hospital. On May 20, 1858, Liholiho and Queen Emma raised $13,000 and the legislature finally provided $7,000. Some two years later, the cornerstone was laid for

the 176-bed Queen's Hospital.

On November 30, 1863, Kamehameha IV died of a stroke. He was 29 years old. He had been very instrumental in establishing laws to regulate the practice of medicine, the prescription of drugs, and, with his wife, had established the first private general hospital in Hawaii —The Queen's Hospital.

Kamehameha V assumed the rule of reigning monarch early in 1864. His major contribution to health care was his interest in the isolation and treatment of leprosy.

In 1845, Dr. Dwight Baldwin, the physician at the Missionary Station at Lahaina, had described the first case of leprosy in Hawaii. This case involved a high chief and his cohorts. In the next few years, leprosy was described on all the Islands and grew in significance as a major public health problem which almost exclusively involved Hawaiians.

Isolated at Kalaupapa

On January 3, 1865, during the second year of his reign, Kamehameha V signed the segregation act which was directed at isolating the lepers at Kalaupapa. At the outset this act was poorly enforced. Later that year, a receiving hospital for the isolation of patients with leprosy was established in lower Kalihi near the sea. On January 1, 1866, the first patient was admitted to the facility at Kalaupapa.

Seven years later, the first permanent Caucasian resident arrived at Kalaupapa — Father Damien. He spent the balance of his life in ministering to the lepers, but died himself of the disease after 16 years of devotion.

In December 1881, there were 653 active cases in the settlement and an estimated total of 1,000 cases in the territory.

Recently in Honolulu, an international conference on leprosy was convened for five days. Some interesting statistics were presented and I would like to share them with you (Table 1). Today, leprosy can be controlled and can be cured with correct treatment and follow-up.

TABLE 1.

	Number of New Cases	Filipino	Samoan	No. America Continent	Born in Hawaii	
1977	27	15	8	1	3	
1978	31	16	10	1	3	1-FIL-HWN 1-CHN-HWN
1979	33	24	5	3	1	
1980 (To. Oct.)	29	20	5	2	2	1-PT-HWN 1-HWN

NUMBER OF NEW CASES IN HAWAII

1886 to October 1980	4,658

NATIONAL RANKING OF STATES — NEW CASES

1st - California	58
2nd - Hawaii	29
3rd - Texas	—

In 1872, the biennial report of the president of the Board of Education noted that "dollars voted for the medical instruction of Hawaiian youth has been expended for that purpose." Ten students of chiefly status were enrolled. This action fulfilled a lifelong desire of Dr. Gerrit Judd to teach medicine to the Hawaiians so that some would become doctors. He had written the first anatomy book in Hawaiian, published by the press in Lahaina.

Kamehameha V died on December 11, 1872. He was a bachelor who left no issue. Princess Pauahi refused the throne. The Kamehameha dynasty was at its end.

For the next 20 years the Hawaiian government reflected instability and lack of strong continuous leadership. In 1873, Lunalilo, the highest surviving chief, was elected by the legislature as king. He reigned for a very short period to December 1873 when he died of tuberculosis, which he had had for several years.

David Kalakaua was then elected by the legislature to assume the crown after a bitter election wherein he defeated Dowager Queen Emma. He was highly motivated to return Hawaii to the Hawaiians, but he succumbed to pneumonia late in 1891 in San Francisco without accomplishing this mission.

In 1891, Queen Liliuokalani, Kalakaua's sister, assumed the leadership of the Hawaiian government by directive of Kalakaua. She, in turn, named Princess Kaiulani as her successor. She, like Kalakaua, wanted to see more of her people, "more browns" in her government.

In 1893, a provisional government was established which deposed the Queen because of the concern regarding her anti-white actions. Dole, Smith, King, Jones, and Hall took over the government without bloodshed.

On August 9, 1885, three crew members arrived in Honolulu on the steamship, Belagic, out of Yokohama. They were infected with cholera and were responsible for starting an epidemic that involved 87 cases and resulted in 64 deaths. During this epidemic several nurses treating the patients also died. The dock front water and the fish were contaminated.

In 1896, a census revealed 8,485 Hawaiians and part-Hawaiians, 22,438 Europeans, and 47,078 Asiatic laborers.

By 1898, Hawaii had renounced its sovereignty form of government and became a republic.

The Plague

About a year later, the bubonic plague broke out in Chinatown. Houses were fumigated with sulfur and sprayed with bichloride. All infected houses were burned. There were 71 cases and 61 deaths. Although dissected rats did show signs associated with the plague and cockroaches and bed bugs were killed with the fumigation and spraying, there were no accounts of any dead fleas or association of the flea with the rat and plague. Burning of the contaminated houses set off a massive uncontrolled Chinatown fire, which cost the government $1,500,000 in reparations.

The year 1900 initiated the beginning of what we accept now as modern medicine. Public school children were examined for contagious diseases. Tuberculosis hospitals were established. Garbage collection and burning was instituted. The first public health nurse was employed, and the first medical group practices and clinics were established.

Hawaii had taken its place in the world of progressive medical service to its people.

In conclusion, I would like to share with you what I believe are a few of the most significant actions and events in

the evolution of Hawaiians and medicine:

In 1788, with the coming of Captain Cook, the Hawaiians mistook the arrival of the first white man as a return of their God, Lono. The western diseases foreigners brought to the Islands devastated the Hawaiian civilization by killing off half the population within the next 40 years.

The year 1819 saw the death of the brilliant and powerful Kamehameha I and the elimination of the *kahuna* and the *kapus*. The Hawaiians had lost their traditional source of exacting discipline, which resulted in their experiencing great mental and spiritual bewilderment.

During the 1830s the haole and Hawaiian leaders had to accept the reality that foreign disease would kill them off if not controlled at the source. Royal orders for ship inspection were poorly instituted and did little to stem the tide of rapid erosion of the Hawaiian population.

During 1850-1870, epidemics of influenza, measles, mumps, whooping cough, scarlet fever, and smallpox killed thousands of Hawaiians, and leprosy was diagnosed on all the major Islands. Laws were established by the legislature that required physicians and a limited number of kahunas to be licensed to practice their profession. Drugs, including a limited amount of opium, could be dispensed legally. The segregation act for lepers was signed by Kamehameha V.

By 1870-1890 the last of the Kamehameha dynasty had served his people. Kamehameha V was dead. Much of the *mana* was slipping away. Leadership was no longer provided by the strong and proud Kamehameha bloodline. Leadership was now obtained through the elective process by the legislature. The unity of purpose which had existed between the Hawaiian chiefs and the *maka ainana* had slipped away. Almost total annihilation of the Hawaiian race by foreign disease contributed to this loss of power.

By the 1900s, the Hawaiians were forced to renounce their sovereignty. The republic had been established and, with this, came a clear shift of power and politics to that of the non-Hawaiian Western culture.

The practice of medicine followed the political example and became dominated by the same non-Hawaiian Western influence to the degree that there are only vestiges of the once highly developed pre-Cook medical discipline.

Yet, the Hawaiian people themselves have managed to evolve from their totally isolated, delicately balanced ecosystem — through the fatal impact with the outside world, where their numbers dropped to critically low levels and near extinction — to the present, where possibly the admixture of other bloods has given them the strength to more clearly identify their own heritage.

The future looks promising, so "keep healthy, Hawaiians!"

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Medical Men Who Helped to Shape Hawaii

BETTY KATSUKI,* Honolulu

Ed. Note: Mrs. Betty Katsuki, wife of HMA member Dr. Robert Katsuki, has been deeply involved in collecting biographies of Hawaii's physicians since 1952. For this extensive work, she should have the title of Archivist for the Hawaii Medical Association!

She has served on the Women's Auxiliary In Memorium Committee, both Honolulu country and state, for the past three decades, and, by her own confession, has spent much time interviewing families and friends of Hawaii's physicians and digging through the Hawaii State Archives.

The In Memorium Committee of the Women's Auxiliary grew from an idea of Mrs. Helen White for an historical scrap book. By now, six hard-cover loose-leaf volumes are on file at the Hawaii Medical Library, including 579 biographies of doctors, with 364 photographs.

An historical note on Mrs. White: she was the wife of Honolulu orthopedist J. Warren White, who was the brother of noted cardiologist Paul Dudley White, who, among other things, brought the first EKG machine to the United States from Germany.

With these 15 capsule biographies, Mrs. Katsuki allows that she has had to leave out more than she could include, and has likely missed someone's favorite doctor of years gone by. She has tried to pick, from the various eras of Hawaii medicine, physicians who were representative of the work of the past century and a half.

Dr. Gerrit P. Judd

Dr. Judd, born April 23, 1803, at Paris, New York, received his medical training at the Medical College, Fairfield, New York, graduating in 1825. Dr. and Mrs. Judd were members of the Third Missionary Company, which arrived in Honolulu March 3, 1827, after a voyage of 148 days. For the next 14 years he served as a physician of the American Board of Missions. In May 1842, he resigned to enter the service of King Kamehameha III, and he thus began a career which was to make him a towering figure in Hawaiian history.

From 1842 to 1853, Dr. Judd held virtually every important government post, including Minister of Foreign Affairs, Minister of Finance, and Minister of Interior; it was his wise counsel that helped establish a stable government. In 1853, during the great smallpox epidemic in which some 3,000 native Hawaiians died, his political enemies made him the scapegoat, and they were able to force his retirement from government service.

He then returned to the active practice of medicine and was one of the first trustees of the Queen's Hospital. In 1856, he was one of the signers of the charter of incorporation of the Hawaiian Medical Society. On July 12, 1873, Dr. Judd died at the age of 70.

Dr. Robert W. Wood

Born in Augusta, Maine, Dr. Wood received his M.D. from Bowdoin College in 1832. Arriving in Honolulu on April 6, 1839, he was the first American non-missionary doctor to settle in Hawaii. From 1839 to 1849, he was physician for the U.S. Seamen's Hospital in Honolulu, and, in 1847, opened the first public pharmacy. Also interested in growing sugar cane, for a time he managed the Koloa Plantation on Kauai, and he was one of the founders of the Royal Hawaiian Agricultural Society in 1850.

Dr. Wood was one of the signers of the charter of incorporation of the Hawaiian Medical Society in 1856 and served as its president for the first three years. He left the Islands in 1866, and died at Jamaica Plains, near Boston, on January 4, 1892.

Dr. William Hillebrand

Dr. Hillebrand was born in Nieheim, Germany, on November 13, 1821. After receiving his medical degree in Berlin, he began his practice in Paderborn, Germany. Poor health forced him to begin a search for a healthier climate, and this ultimately brought him to Hawaii in December 1850. Here he began a successful practice and numbered the royal family among his patients. He was physician at the Queen's Hospital, a member of the Board of Health, physician at the Insane Asylum, and was part-owner of a drug store at Hotel and Fort streets. In 1856, he was one of the signers of the charter of incorporation of the Hawaiian Medical Society.

Dr. Hillebrand is best remembered as a world-renowned botanist. In 1865, he made a trip to the Far East, having been commissioned to select plants and animals for introduction to the Islands. Many rare trees, planted by the doctor himself, are still to be seen on the grounds of The Queen's Hospital and at Foster Gardens, which was the site of his home. His monumental "Flora of the Hawaiian Islands," mentioning some 250 species of rare plants then unknown to the botanical world, was published posthumously. Leaving Hawaii in June 1871, Dr. Hillebrand returned to Europe, and died at Heidelberg on July 13, 1886, at the age of 64.

Dr. John S. McGrew

Dr. McGrew was born at Lancaster, Ohio, on December 23, 1825. At the age of 15, he entered Oxford College

* Chairman, HMA Auxiliary In Memorium Committee

and received his M.D. from Ohio Medical College in 1847. During the Civil War, he served as an army surgeon under generals McClellan, Sherman, and Grant. A projected world tour brought Dr. and Mrs. McGrew to Honolulu in March 1867. He became so enchanted with the Islands that he abandoned his tour to settle here.

Soon active in the medical community, he was appointed medical officer of the U.S. Marine Hospital in 1869, and was a member of the Board of Health, 1880-1881. He crossed swords unsuccessfully with The Queen's Hospital over its policy that all patients were solely under the care of the staff physicians appointed by the Board of Trustees. He was honored in 1887 by being elected vice-president of the International Medical Congress. After a hiatus of some 32 years, during which there were no known records of any meetings of the Hawaiian Medical Society, Dr. McGrew gathered together a group of doctors to draw up a constitution, and in May 1892 the Medical Association of Hawaii was founded. As president of the group, Dr. McGrew continued in office from 1892 through 1896. Intensely interest in politics, he was an ardent advocate of annexation, and he fought tirelessly until Hawaii was annexed in 1898. His efforts won him the title, "Father of Annexation." Dr. McGrew died on November 17, 1911, at the age of 85.

Dr. Arthur A.S. Mouritz

Dr. Mouritz was born May 1856 in London. At the age of 16, he began his medical studies at Oxford University, and, in 1879, became a licentiate of the Royal College of Physicians, London, and of the Royal College of Surgeons, England. He arrived in Honolulu on May 3, 1883, as ship's surgeon aboard the S.S. Abergeldie and he decided to remain. For a short time in 1883, he served as secretary to the Board of Health. From 1884 to 1887, Dr. Mouritz was physician at Kalaupapa where he worked closely with Father Damien. Due to his intimate association with Father Damien, he was the principal witness before the ecclesiastical court, convened in 1938 to get details of Father Damien's life at Kalaupapa. Starting in 1888, he was appointed government physician for the rest of Molokai and also carried on a private practice. In 1905, he practiced on Kauai, and, in 1907, moved to Honolulu, where he practiced until his death on December 1, 1943, at the age of 87.

Known mainly for his work at Kalaupapa, from 1893 to 1894, he was an expert observer of the Goto method of treating leprosy, which he found more harmful than helpful. He was also the author of several books, but is best remembered for "The Path of the Destroyer" (1916), which dealt with leprosy and is now a collector's item.

Dr. Clifford B. Wood

Born in Cincinnati, Ohio, December 14, 1859, Dr. Wood was an 1883 graduate of the Chicago College of Physicians and Surgeons. Arriving in Honolulu on December 25, 1886, he soon had an appointment as government physician for the Koolaupoko district of Oahu. In 1887, he became city physician for Honolulu, but after four months resigned to give more time to his private practice.

About 1888, he was appointed physician for Lunalilo Home, which cared for indigent Hawaiians. In 1890, he was named assistant physician at The Queen's Hospital. Later he became the first doctor to serve on its Board of Directors, and he was founder of the Thursday Morning Clinics.

He was named to the Board of Health in 1894 and, in 1900, became president. In this capacity, he headed efforts to fight the bubonic plague which broke out that year. In 1903, Gov. Frear appointed Dr. Wood to the Board of Medical Examiners, of which he became president. Dr. Wood was president of the Hawaii Medical Association in 1898 and again in 1925. Like Dr. McGrew, he actively worked towards annexation, and, in 1895, was one of four new members elected to the Council of the Republic. Dr. Wood died on April 26, 1939, at the age of 79.

Dr. Iga Mori

Dr. Mori was born in Ishikawa, Japan, on February 11, 1864. Educated at the Naval Medical College in Japan, from which he graduated in 1887, he later attended Cooper Medical College and received a degree in 1891. He first came to the Islands in 1890 as physician for the Bureau of Immigration, but left in 1894 to become chief surgeon for the First Corps of the Japanese Red Cross in the Sino-Japanese War. In 1895, he returned to Hawaii to settle permanently.

During his 56 years as a physician and surgeon, Dr. Mori was not only a leader among the Japanese doctors, but also represented the Japanese community in civic and cultural affairs. In 1896, he became a member of the Hawaii Medical Association, and, in 1914, was given an honorary membership in the Honolulu County Medical Society, the first oriental to be so honored. He was president, for several terms, of the Japanese Medical Society, and was a founder of the Japanese Benevolent Society, serving as president for several terms.

Dr. Mori was instrumental in establishing the Japanese Hospital (now Kuakini), serving as president, superintendent (1905-1906), and on the Board of Trustees. Keenly interested in promoting good relations between the United States and Japan, he was an active member, trustee, and vice-president of the Pan-Pacific Union. He was one of a group of five prominent men who, in 1917, founded the Nuuanu YMCA, the first branch not to be segregated along racial lines. On May 12, 1951, Dr. Mori died at the age of 87.

Dr. Jay M. Kuhns

Born in Cooperstown, North Dakota, on September 13, 1884, Dr. Kuhns came to Hawaii with his family in 1898. After holding down a variety of jobs, he discovered that in order to achieve his ambition to become a doctor he would need high school credits. At the age of 24, he entered McKinley High School and at the end of one year passed all his subjects except algebra. He then entered the College of Hawaii, and after two years was accepted at Washington University in St. Louis where he received his M.D. in 1915. In 1916, he became resident physician at the McKee Sugar Company, Kealia, Kauai, and later moved to Lihue Plantation and also served the Rice Ranch,

Grove Farm, and Niihau, where requests for the doctor came by carrier pigeon.

Dr. Kuhns' greatest satisfaction came from obstetrics. After delivering 4,000 babies, he stopped counting. He delivered babies by flashlight and gasoline lamp, and once did a Caesarean section on a low Japanese table. He was threatened with death by one patient's husband if an operation on the wife was not successful . . . it was! He was a member and served as president of the Kauai Medical Society and, in 1946, was president of the Hawaii Medical Association. In 1957, the Pan-Pacific Surgical Association offered Dr. Kuhns a full membership, rather than the customary associate membership, in recognition of his outstanding achievements. The following year the Hawaii Medical Association honored him as "the general practitioner of the year," the first such award to be given. Dr. Kuhns died in Honolulu on April 1, 1964, at the age of 79.

Dr. Eric A. Fennel

A pioneer pathologist in Hawaii, Dr. Fennel was born in Cincinnati, Ohio, on September 24, 1887, and graduated from the University of Cincinnati College of Medicine in 1912. Shortly before World War I, he entered the Army Medical Corps. After graduating from the Army Medical School, he was kept on the staff to work on typhoid vaccines. Coming to Hawaii in 1919 as department pathologist at Tripler Army Hospital, Dr. Fennel resigned in 1920 to join with Dr. George Straub in the formation of Straub Clinic, with which he was associated until his death.

Dr. Fennel organized the first laboratory at The Queen's Hospital, and for many years was consulting pathologist there and also at Leahi, Children's, St. Francis, and Kapiolani hospitals. Keenly interested in leprosy, he was a member of the Board of Hospital and Settlement from the time of its establishment in 1932. He was a member of a number of professional societies, and was honored by membership in Alpha Omega Alpha when a chapter was founded at his school six years after his graduation. Dr. Fennel was a member of the Honolulu County Medical Society and served two terms (1944 and 1945) as president of the Hawaii Medical Association. Before World War II, he suggested the establishment of the Blood Bank of Hawaii, and he had his own plasma bank in operation on December 7, 1941. Dr. Fennel died December 24, 1957, at the age of 70.

Dr. Nils P. Larsen

Born in Stockholm, Sweden, on June 15, 1890, Dr. Larsen was a 1913 graduate of Cornell University Medical School. In 1922, he came to Hawaii to become pathologist at The Queen's Hospital, and he soon was made medical director. During the next 20 years he established an occupational therapy service, a research department, helped develop a training school for nurses, instituted weekly clinics and edited "The Queen's Hospital Bulletin." In 1930, he became medical adviser to the Hawaiian Sugar Planters' Association, and developed a medical and health program which gave Hawaii's plantations the lowest incidence of disease and mortality among American industries. He also led the fight to improve Hawaii's milk supply, with the result of a sharp drop in infant deaths. In 1950, he was a delegate to the Hawaii Constitutional Convention.

To name but a few of Dr. Larsen's awards: In 1951 he was the first honorary president of the Pan-Pacific Surgical Association. After serving two terms (1927 and 1945) as president of Honolulu County Medical Society and a term as president of the Hawaii Medical Association in 1954, he was given the HMA's distinguished service award in 1956. Awarded the University of California's prestigious Gold-Headed Cane, he became the second physician outside of the continental United States to win this honor. He held honorary degrees from Massachusetts State College and from the ancient University of Lund in Sweden, and he was decorated by the governor of New York, the king of Cambodia and the king of Sweden. Dr. Larsen died on March 19, 1964, at the age of 73.

Dr. Joseph E. Strode

Dr. Strode was born in Independence, Missouri, on March 6, 1891, and received his M.D. from Washington University, St. Louis, in 1915. After military service in World War I, he went into private practice in Honolulu in August 1919. Joining Straub Clinic on January 1, 1922, he specialized in surgery for 49 years and is credited with having trained more surgeons than any other doctor in Hawaii. Dr. Strode was on the staff of every hospital in Honolulu, served as consultant in surgery to the U.S. Public Health Service, and was on the teaching staff of Tripler Army Hospital.

He was the first doctor in Hawaii to be elected to the very selective American Surgical Association and for a number of years was the only physician here to be so honored. Dr. Strode was founder and president of the Honolulu General Surgical Society, served as president of the Hawaii chapter of the College of Surgeons, had two terms as president of the Hawaii Medical Association (1923 and 1931) and, from 1960 to 1963, headed the Pan-Pacific Surgical Association. His picture appeared on the cover of "Modern Medicine" for August 7, 1961, with an accompanying article. In 1968, he was made a senior member of the exclusive Pacific Coast Surgical Association. Dr. Strode died in Honolulu on August 13, 1972, at the age of 81.

Dr. Forrest J. Pinkerton

Dr. Pinkerton was born in Lowell, Indiana, on January 23, 1892. Educated on the Mainland, he received his M.D. in 1914 from Chicago College of Medicine and Surgery (now Loyola). Coming to Hawaii as an army medical officer aboard a transport in 1917, he resigned from the service in 1919 and opened an office in Hawaii, specializing in EENT. Dr. Pinkerton was on the staff at Queen's from 1920 until his retirement in 1964 and served on its Board of Directors for many years. He was consultant to Tripler Army Hospital, the Board of Health, Kalaupapa, and was on the staff of all the local hospitals.

Dr. Pinkerton was a co-organizer of the Pan-Pacific Surgical Association in 1928, became president in 1948, and also held membership in more than 20 professional societies. Serving on countless committees for both the Honolulu Medical Society and the Hawaii Mecical Association, he became president of the former in 1923 and

served two terms as president of the HMA in 1924 and 1929. A few of his many honors were: the Order of the Splintered Paddle from the Honolulu Chamber of Commerce; a distinguished service award in 1970 from the American Association of Blood Banks; the Lane Bryant Foundation award for volunteer service to the community; and recognition by both Honolulu Medical Society and Hawaii Medical Association. On his retirement in 1964, Hawaii doctors established the Forrest J. Pinkerton Research Fund to encourage blood and tissue research as recognition of his long service in blood banking. Dr. Pinkerton died on December 29, 1974, at the age of 82.

Dr. Frederick K. Lam

Dr. Lam was born in Honolulu on December 18, 1894. After working his way through Creighton University, he attended St. Louis University School of Medicine, where his only financial help was a $500 scholarship. He received his M.D. in 1920. He is best remembered by the Chinese community for his work on clonorchiasis (liver fluke). In the 1920s, all Chinese found to have liver fluke were deported. Dr. Lam's research showed that only when an infected person ate a certain type of snail could he transmit the disease to others, and that particular snail did not exist in Hawaii. Appearing before a special board of the U.S. Public Health Service, Dr. Lam was able to persuade them that the disease was not communicable in Hawaii. Thus, the restrictions were removed and those persons who had been deported were allowed to return to the Islands.

In addition to an active practice, Dr. Lam served from 1929 to 1937 as director of communicable diseases, and of the Bureau of Maternity and Infancy Hygiene and Crippled Children for the Board of Health. He was the first oriental to be elected president of the Honolulu County Medical Society in 1942; he also served three terms as treasurer and was vice-president of the Hawaii Medical Association. He helped raise thousands of dollars for the United China Relief and other Chinese benevolent causes, as well as for the American Red Cross. In 1963, he was the recipient of the St. Louis University Alumni Merit Award and, in 1970, was selected for special recognition from the HMA. On August 19, 1974, Dr. Lam died at the age of 79.

Dr. Ransom J. McArthur

A native of East Barre, Vermont, Dr. McArthur was born on February 2, 1902. He received his M.D. from the University of Oregon Medical School in 1929. Dr. McArthur came to Maui in September 1931 to accept a position on the staff of Kula Sanitarium. After five years at Kula, he became superintendent at Malulani Hospital, Wailuku, a post he held until 1945, when he entered private practice in Wailuku. With the exception of a period of less than a year when he joined his brother in private practice in Portland in 1946, Dr. McArthur practiced in Wailuku until his death.

He was a member of the Maui County Medical Society (president 1939-1941 and 1942-1943), president of the Hawaii Medical Association (1952), served as president of the Maui Health Council (1947), and was a member of the Maui Unit of the American Cancer Society and the American College of Tuberculosis Physicians. For over 20 years, Dr. McArthur was active in amateur boxing, first as ringside physician and then as deputy boxing commissioner for Maui. He was also a member of the Maui Rotary Club and the Maui Chamber of Commerce. Dr. McArthur died in Honolulu on April 8, 1964, at the age of 62.

Dr. William N. Bergin

Born April 7, 1907, in Honolulu, Dr. Bergin was educated at St. Louis College, Honolulu, and then attended Creighton University, where he received his M.D. in 1933. He first practiced in Honolulu for a short time, spent a year in Kona, and was at Kula Sanitarium, Maui, for seven months before moving back to the Big Island. From 1943 to 1944, Dr. Bergin was plantation physician at Laupahoehoe and the following five years were spent at Pepeekeo in plantation medicine. In May 1949 he settled permanently in Hilo, where in 1961 he was co-founder of the Hilo Medical Group.

Very active professionally, Dr. Bergin was president of the Hawaii County Medical Society (1941), president of the Association of Plantation Physicians (1946), president of the Hawaii Medical Association (1958), and a director of the Hawaii Medical Service Association. He was one of three doctors who received a special award for outstanding work at the annual meeting of the Plantation Physicians in 1958, and two years later he was named "Outstanding Physician in the State" at the annual HMA meeting. The Hawaii County Council passed a resolution in 1975 honoring him for his many contributions to the Big Island in medicine and community service. Dr. Bergin died in Hilo on December 25, 1975, at the age of 68.

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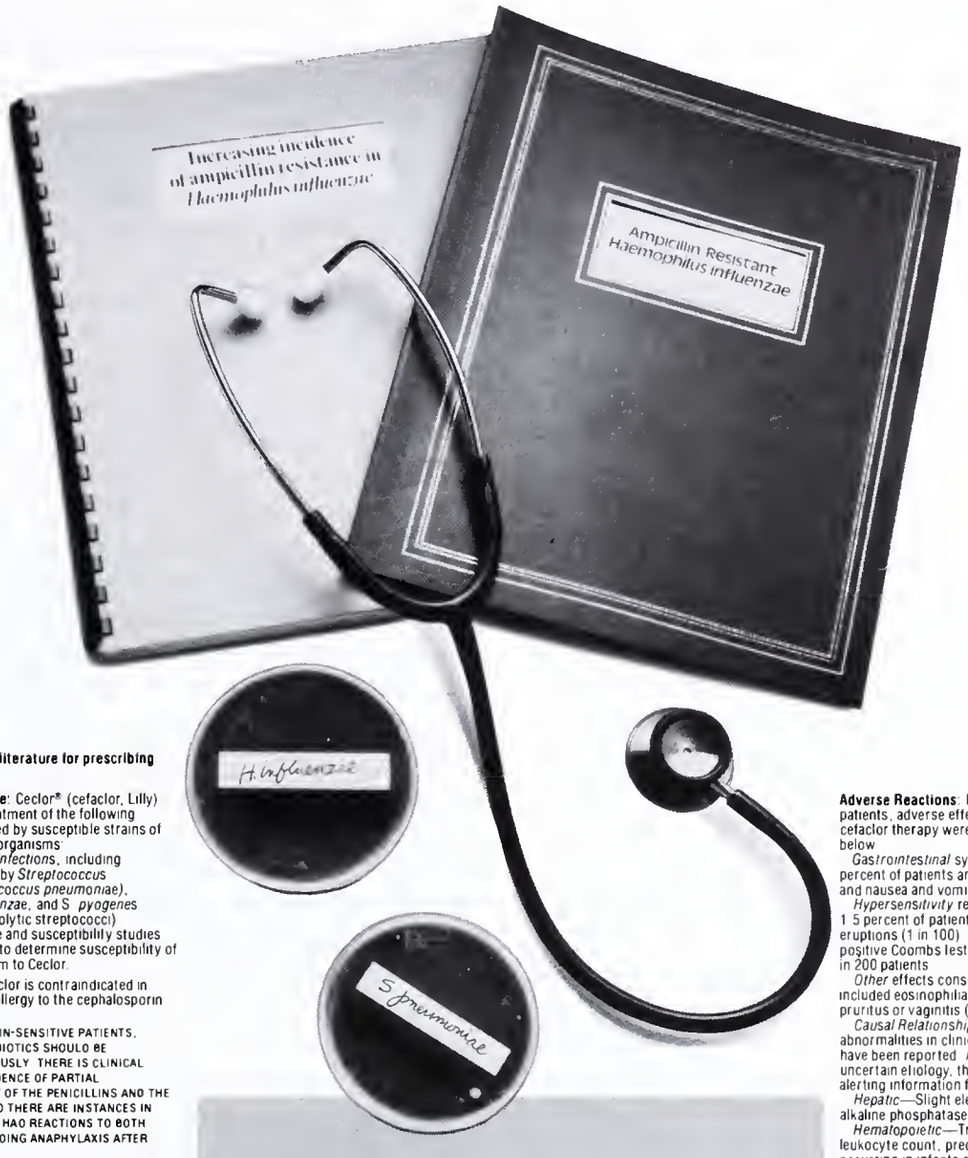
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Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

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Adverse Reactions: In clinical studies in 1493 patients, adverse effects considered related to cefaclor therapy were uncommon and are listed below.

Gastrointestinal symptoms occurred in about 2.5 percent of patients and included diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions were reported in about 1.5 percent of patients and included morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occurred in less than 1 in 200 patients.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGDT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [0703798]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.[8]

Note: Ceclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

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Health and Medical Firsts in Hawaii

ROBERT C. SCHMITT, M.A.*

Determining the date of major innovations — medical and otherwise — is a difficult process. Some important developments, like major public health legislation, large-scale epidemics, or construction of a hospital, are routinely recorded at the time and subsequently cited by generations of historians. Other introductions, equally far reaching, are often ignored, their origins lost and unmentioned in standard reference works. No general history of Hawaii, for example, refers to the first use of anesthesia by an Island surgeon, the earliest X-rays, or the coming of antibiotics. Even when events have been recorded, moreover, there is frequent confusion with respect to names, places, and dates.

These problems seem to be especially evident in the health and medical history of Hawaii. This chronology has consequently been drafted as a modest effort to sort out some of the more important introductions to public health and medical care in the Islands:

1778: The first Western medical practitioners to visit Hawaii were the six surgeons and surgeon's mates of the *Resolution* and *Discovery*, the two British ships under the command of Captain James Cook, dropping anchor off Waimea, Kauai, on Janaury 20. The surgeons were William Anderson, David Samwell, and John Law; the surgeon's mates, Robert Davies, James Snagg, and William Ellis.[1]

The first Island residents to be treated by these ship's surgeons were several Hawaiians who came aboard at Maui, November 30, 1778, complaining of venereal disease, and were given medication.[2]

c. 1793: Don Francisco de Paula Marin arrived in Hawaii, eventually to become the first resident physician of record (other than native practitioners, the *kahuna lapa'au*). Marin, an Island resident until his death in 1837, apparently lacked any formal medical training.[3]

1804: The *oku'u*, now thought to have been Asiatic cholera, was Hawaii's earliest recorded epidemic. Although later writers reported much higher figures, the death toll was probably less than 15,000.[4]

First Trained Doctor

c. 1811: Juan Elliot d'Castro (or John Elliot de Castro), formerly a surgeon on naval and merchant vessels and at a Rio de Janeiro hospital, came to Hawaii and served as secretary and physician to Kamehameha I. He was apparently the first trained foreign doctor to reside in the Islands.[5]

1820: On April 12, Thomas Holman, the earliest of the mission doctors, arrived with the first company of American Protestant missionaries.[6]

1823-1826: At some time during his 3½-year stay in the Islands, Dr. Abraham Blatchley obtained a supply of cowpox vaccine from London by way of Nantucket, but by the time he received the shipment it was "too old" and "good for nothing."[7] This is apparently the earliest reference to vaccination against smallpox.

1824: On February 17, following the death of William Beals in Honolulu, "the chest of the corpse . . . was opened by Dr. Law with a view to ascertain if possible the nature of his disorder."[8] This autopsy seems to have been the first mentioned in the historical record. Dr. Law, a Scotsman, was the king's physician and surgeon.

1833: The first of the hospitals for foreign sailors, the "British Hospital for Seamen," was established around this time. It actually consisted of board in a "hovel" owned by an English tavernkeeper.[9]

1834: Missionaries on Kauai and Oahu commenced the collection of statistics on births and deaths, the earliest vital statistics available for the Islands.[10]

1835: In January, Dr. Alonzo Chapin, a mission physician, extracted one of a Mr. Dibble's teeth — perhaps the earliest recorded reference to dental surgery in Hawaii.[11]

1836: "The earliest recorded public action for the protection of health in the Hawaiian Islands," according to Lee, "was a notice to the pilot of Honolulu forbidding him to board any vessel until he had ascertained the health condition aboard. It stated that if smallpox was aboard, the vessel was to anchor and fly a yellow flag." This order was dated August 1.[12]

Seamen's Hospital

1837: The first real hospital, the Hospital for American Seamen, was established in rented quarters in Waikiki.[13]

1838: Lahainaluna Press issued the first medical work ever printed in the Hawaiian language, Dr. Gerrit P. Judd's 60-page *Anatomia*, illustrated with 19 copper plates containing 58 engravings.[14]

1839: King Kamehameha created Boards of Health, consisting of three persons for each harbor, and empowered to enforce quarantine regulations.[15]

By June, "eight or ten thousand" natives had been vaccinated at Honolulu, in Hawaii's first mass immunization effort, following a smallpox scare.[16]

1845: Dr. Dwight Baldwin treated a high chief who apparently had leprosy, caught some five years earlier; this seems to have been the earliest recorded case, although it was not recognized at the time.[17]

1847: Three public pharmacies — apparently Hawaii's first — opened in Honolulu. From January 2 to April 10, Dr. G. Watson advertised "his professional services" and "office, next door to C. Brewer & Co.'s, where may be found a general assortment of Drugs and Medicines, Perfumes, Fancy Soaps, &c."[18] On July 1, the clerk of the

* State Statistician
Hawaii State Department of Planning and Economic Development

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Home Office wrote to Dr. Robert W. Wood to state that Wood was keeping "a place of business for the Retail Vending of Drugs, Medicines, Perfumery &c of foreign production & manufacture" and hence required a business license. Five days later a similar letter was sent to Dr. G.W. Hunter.[19] Halford later referred to Wood's 1847 store as "Hawaii's first public pharmacy," but Watson's drug store probably preceded it.[20]

On August 26, 1847, Honolulu readers learned of Morton's demonstration, some months previously in Boston, of "his preparation to produce sleep, to a person about to undergo the operation of the extraction of a tumor from the neck." This article, an undated excerpt from the Boston Journal, was the first published reference in Hawaii to anesthesia.[21]

Public Water Supply

Beginning in September 1847, a lead water main was laid connecting a taro patch mauka of Beretania Street with the Harbor Master's office at the foot of Nuuanu Avenue. Built primarily for the convenience of shipping, this main has been described as "the first attempt to establish a public water supply." After completion of the Bates Street reservoir in 1851, nearby businesses and homes as well as ships in Honolulu Harbor were connected with the new piped water system.[22]

On December 11, 1847, Dr. M.B. Stevens, surgeon-dentist, announced his arrival in Honolulu and his readiness "to perform any operation on the Teeth that may be required," including the insertion of teeth "from one to an entire sett [sic], either on Pivot or Gold Plate." Stevens was probably the first professional dentist to practice in the Islands. After 5 weeks he discontinued his advertisements and apparently moved on.[23]

1850: On February 16, Dr. Charles H. Wetmore, the mission physician in Hilo, administered ether to his wife, Lucy, as she was giving birth to their first child. Dr. Wetmore's subsequent account of this delivery, addressed to Dr. Dwight Baldwin on Maui, appears to be the earliest known reference to the use of general anesthesia in the Islands.[24]

On December 10, 1850, King Kamehameha III appointed the first members of the Board of Health, established by a resolution of his Privy Council.[25]

1851: John Mott-Smith, Hawaii's first resident dentist, arrived. A native of New York, Mott-Smith had studied dentistry from the textbooks of a friend attending dental college, passed the New York dental exams, and practiced in Albany.[26]

1852: The first private hospital, "a Hydrop establishment in Nuuanu Valley," was opened in May by Dr. S. Porter Ford and Dr. George A. Lathrop.[27]

1853: A smallpox epidemic, Hawaii's first, swept Oahu and the other Islands from May to the end of the year, killing more than 5,000.[28]

Flush Toilets Installed

1856: Flush toilets, apparently the first in the Islands, were installed in King Kamehameha IV's new house on the Iolani Palace grounds during May and June.[29]

On July 19, 1856, a charter was granted to the Hawaiian Medical Society, the first such organization in the Islands. At the first meeting, held August 13, Dr. R.W. Wood was elected president.[30]

1859: The Queen's Hospital opened in temporary quarters on August 1 and in December 1860 moved to its permanent 124-bed structure — the first major hospital in the Islands.[31]

'You Need to Have A License'

Legislation enacted the same year made it unlawful "for any foreigner, whether naturalized or otherwise, to practice in this Kingdom as a physician or surgeon, for compensation or reward, unless he shall first have presented to the Board of Health . . . evidence of his professional qualifications and good moral character and obtained a certificate of approval from said Board, and a license from the Minister of the Interior."[32] Six years later, this requirement was broadened to include native as well as foreign physicians.[33]

1862: The legislature voted to establish an insane asylum.[34]

1865: Kalihi Receiving Station, the first facility for leprosy patients, was authorized on January 3 and opened November 13.[35]

1866: The leprosy settlement at Kalawao, Molokai, received its first group of inmates on January 6.[36]

On August 25, the first patients were moved into the newly opened insane asylum at Kapalama.[37]

1868: Legislation to regulate the sale of deadly poisons was approved June 23.[38]

1869: John M. Whitney, D.D.S., M.D., described as "the first graduate dentist to practice in Honolulu," opened his office.[39]

1870: On November 9, Dr. Gerrit P. Judd opened Hawaii's first medical school, with funds provided by the 1868 and 1870 legislatures. The student body numbered 10. The class completed its work in October 1872 and the school closed.[40]

Street Cleaning Commences

1878: Regular cleaning of the streets of Honolulu commenced in July.[41]

1882: For the first time, the Board of Health referred in its biennial report to "germs."[42] Two years later, other new words appeared: bacillus, bacteria, disinfectant, and micro-organism.[43]

On August 5, 1882, the legislature acted "to provide for licensing dairies, and the sale of milk; and for the inspection of milk in the city of Honolulu."[44]

Also in 1882, Frances M. Wetmore, M.D., completed her medical training in Philadelphia and returned to the Islands. After unsuccessfully applying for an appointment as dispensary physician in Hilo, she began practicing with her father, Dr. Charles H. Wetmore.[45] She appears to have been Hawaii's earliest woman physician. (Another candidate for this title was Sarah E. Peirce, M.D., who "practiced medicine here for a few years before and after her

marriage in January 1885 to Dr. Nathaniel B. Emerson."[46] Although later described as Hawaii's "earliest pioneer woman physician," she was not listed in the city directory until 1884.[47]

Microbiology Arrives

1883: Dr. Edward Arning, described as "the first microbiologist in Hawaii," arrived on November 8 to study leprosy for the Board of Health.[48]

On the next day, seven members of a Franciscan order, the Sisters of Charity, arrived to serve as nurses at Branch Hospital in Honolulu and Malulani Hospital on Maui.[49]

1886: At The Queen's Hospital, "Trustee C.R. Bishop announced that the first professional nurse, Mrs. Mary Adams, had been engaged," but her duties were largely those of a matron.[50]

1889: The Queen's Hospital reportedly employed its "first trained nurse," variously identified as Mrs. Johnston,[51] Mrs. Miller,[52] or left unnamed.[53]

1890: Kapiolani Maternity Home was opened in June.[54]

1891: Meat inspection was begun in Honolulu.[55]

Our First Malpractice Suit

Later that year, The Queen's Hospital recorded its earliest medical malpractice suit. On October 24, Dr. Robert McKibbin resigned from the staff following charges by Fred Humphreys Powers that McKibbin had seriously mishandled Powers' dislocated shoulder following an accident in December 1889.[56]

1892: The Queen's Hospital employed its "first regular graduate trained nurses," Miss Margaret A. Carroll and Miss Nina Cook.[57] As noted previously, similar claims have been made for nurses hired in 1886 and 1889, but the question remains unresolved.

On December 19, "an act to regulate the practice of dentistry" established a Board of Dental Examiners and required certification for practicing dentistry.[58]

1896: Early in February, Honolulu newspaper readers learned of Roentgen's discovery of the X-ray.[59]

X-rays Come to Hawaii

On September 8, Dr. Lauschner, acting surgeon of the S.S. Australia, gave the first Island demonstration of the X-ray. Speaking before some 75 invited guests in Pauahi Hall, Punahou, Dr. Lauschner exhibited X-ray plates he had made, and concluded by projecting first his hand and then a coin-filled purse on a fluoroscopic screen.[60]

1899: The Honolulu Sanitarium, opened at 1082 South King Street in July 1896, reported that "a fine Satic [static] electrical machine, with an X-ray attachment, is in operation, and is for the use of physicians, and for giving special electrical treatment."[61] This appears to be the earliest reference to the use of the X-ray in an Island institution.

Sewers Connected

Early in August, work was finally commenced on the Honolulu sewer system. By mid-1901, almost 34 miles of sewers had been completed, and the Governor could report that "in a few months the entire business section of the city will be using the system, together with a greater portion of the residence district."[62]

1900: The Victoria Hospital Association was established on April 4 to provide "for the care and treatment of persons suffering from incurable diseases except leprosy." Originally located in Kakaako, Victoria Hospital was renamed the Honolulu Home for Incurables in 1901, moved to its present site in Kaimuki in 1902, renamed Leahi Home in 1906, and eventually restricted to tuberculosis patients, the first such hospital in Hawaii.[63]

Rat-Proof Levy

The Quarantine Wharf Committee was organized during the bubonic plague of December 1899 to April 1900. Late in 1901, this group renamed itself the Shippers' Wharf Committee and assessed its members 15 cents per ton on imports to rat-proof all the wharves of Honolulu and keep them fumigated. This levy, reduced in 1902 to 10 cents, was continued until 1950, and under the administration of the Public Health Committee of the Chamber of Commerce of Honolulu was used to support a wide variety of important public health programs.[64]

1903: Laws to regulate the practice of dental surgery and pharmacy were enacted.[65]

Rubber Gloves in Surgery

Dr. James Robert Judd, the first to use rubber gloves in surgery in Hawaii, began his practice in Honolulu.[66]

1904: The earliest known reference to X-rays in the surgical records of The Queen's Medical Center describes a radiograph of the fractured leg of G.W. Kirkaldy, admitted September 6 and attended by Dr. Hoffman[67]

1905: An Hawaiian schoolboy, admitted to The Queen's Hospital on March 29, was given an agglutometer test by Dr. Hoffman. This seems to be the earliest known reference to a blood test at that institution.[68]

1906: Palama Settlement provided the first public health nurse in the Islands.[69]

On November 18, Dr. A.W. Morton of San Francisco demonstrated spinal cocanization at The Queen's Hospital. The first case operated on using this technique was one of double inguinal hernia.[70]

1907: Tripler Hospital, the first military hospital in Hawaii, was built in Moanalua.[71]

1909: Kauikeolani Children's Hospital, the first Island hospital devoted entirely to the care of children, was erected in Honolulu.[72]

1910: Children's Hospital opened a training school for nurses, the first in Hawaii. It was never accredited, and in 1917 it was merged with the school at The Queen's.[73]

1911: The Queen's Hospital installed its first X-ray equipment.[74]

Workmen's Comp Begins

1915: The Workmen's Compensation Act, providing for the compensation of employees for injuries sustained on

their jobs, was passed by the legislature.[75]

1916: In January, The Queen's Hospital School of Nursing was established. Five years later it became the first accredited nursing school in Hawaii.[76]

1917: A new law established a board of registration of nurses and created the title of registered nurse for those passing an examination.[77]

1921: In March, the first patient was admitted to Waimano Home (originally called the Home for Feeble-Minded Persons) above Pearl City.[78]

An act of the territorial legislature, approved April 21, created a Psychological and Psychopathic Clinic at the University of Hawaii, "to investigate the nature, causes, treatment and consequences of mental disease and defect within the Territory of Hawaii."[79] The clinic's long-time director and chief psychologist, Stanley D. Porteus, arrived the following year.[80]

Also in 1921, Dr. George F. Straub and four other physicians founded "The Clinic," Hawaii's first group practice, at 401 South Beretania Street, Honolulu.[81]

In the same year, Dr. Eric Fennel gave the first recorded blood transfusion in Hawaii.[82]

The first classified telephone directory for Oahu appeared in November 1921. A section on "Physicians & Surgeons" listed 80 numbers; one on "Osteopathic Physicians" listed 4.[83]

1922: Dr. Robert B. Faus, recently arrived from psychiatric work in Chicago to become physician for the City and County of Honolulu, began to treat psychiatric patients on an outpatient basis.[84]

1923: The Queen's Hospital introduced the use of insulin.[85]

1926: Dr. Mon Fah Chung, a neurologist, returned to Honolulu and began to offer private psychiatric treatment in addition to his practice of neurology.[86] (Although Dr. Chung appears to have been Hawaii's first psychiatrist in private practice, he did not list himself in the telephone directory under this specialty until 1953. This was 8 years after the first such listing, by Dr. Richard D. Kepner.)[87]

The First Real Ambulance

1928: The first "real ambulance, i.e. a conveyer built from the wheels up with the sole purpose of functioning as an ambulance," was put into operation in Honolulu.[88]

1929: Counseling and services in contraception and sterilization were first offered on the plantations. In Honolulu, Palama Settlement established a male sterilization clinic in 1930 and a birth control clinic in 1931.[89]

1931: On October 31, punchcard equipment was installed in the Bureau of Vital Statistics of the Territorial Board of Health.[90] This installation, the first in territorial or county government in Hawaii, greatly facilitated the processing of data on births, deaths, morbidity, and other public health concerns.

1935: The Bureau of Sight Conservation and Work with the Blind, described as "the first autonomous territorial casework organization supported solely by taxation," was established as the successor to the Governor's Committee on Conservation of Sight, formed two years earlier.[91]

1937: Sulfanilamide was first put to use by Board of Health,[92] Queen's Hospital,[93] and Navy[94] physicians, primarily for the treatment of gonorrhea.

1938: On June 1, the Hawaii Medical Service Association initiated prepaid medical and hospital care for school teachers and social workers. Within a short time, membership was extended to industrial groups of five or more employees, and in 1946 to the Neighbor Islands.[95]

1939: The Oahu Health Council held its first meeting November 24.[96]

1941 — Big Year

1941: On June 2, the first blood was drawn at the newly opened Honolulu Blood and Plasma Bank.[97]

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On December 7, many U.S. soldiers and sailors seriously wounded in the Japanese attack on Pearl Harbor were reportedly saved by sulfanilamide in what was described as its "first big wartime test."[98]

1943: Penicillin reached Hawaii, but was initially restricted to military use. Beginning in late July, the new drug was used at Aiea Naval Hospital for the treatment of gonorrhea.[99]

Local Penicillin

Early in October, officials decided to undertake the production of penicillin locally at the HSPA Experiment Station on Keeaumoku Street, and by the end of the year significant quantities were being produced.[100]

1944: Penicillin was first made generally available for civilian use, with designation of The Queen's Hospital as the distributing center of the drug for civilian purposes throughout the territory.[101] The treatment of local cases was soon being described.[102] Between July 1944 and March 15, 1945, 1,049 patients received 774.8 million units under this program.[103]

1946: The first commercial shipment of streptomycin reached Hawaii early in November.[104] In December, physicians at Leahi Hospital began using the drug on tuberculosis patients, sometimes with striking results.[105]

1952: The University of Hawaii Nursing School enrolled its first students, in September.[106]

1954: On December 20, at The Queen's Hospital, the first arterial transplant was successfully carried out on a patient with a gunshot wound of the ellbow. About 4 inches of the artery were successfully transplanted.[107]

1955: Psychiatrists at Territorial Hospital began using the new tranquilizing drugs in their treatment of patients, often in conjunction with group psychotherapy techniques.[108] The first modern tranquilizer used at the hospital was chlorpromazine.[109]

Hypothermia Introduced

On November 30, at The Queen's Hospital, a Honolulu neurosurgeon removed a tumor from the brain of John Y. Woo after first inducing hypothermia by means of ice packs. The Potts boot had been used in 1947 for refrigeration of a local area (a leg), but this was the first Island in-

stance of induction of general hypothermia for a major operation.[110]

1958: The Kaiser Foundation Health Plan went into effect on November 15, 11 days after the new Kaiser Medical Center in Waikiki had opened its doors to patients of member doctors and 2 days after formal opening ceremonies.[111] The Kaiser-Permanente medical care program was the first closed-panel health maintenance organization in Hawaii.

1959: On December 2, a surgical-technical team of 14 at The Queen's Hospital performed the first open-heart surgery in the Islands. The patient was Harumi Yoshimoto of Hilo.[112]

1960: Enovid was approved as a birth control pill and became the first oral contraceptive available for general use in Hawaii. Previously Enovid had been used for endometriosis and cycle control, and was stocked at Straub Clinic as early as 1958.[113]

1962: The Department of Public Health was established in the Graduate School of the University of Hawaii in July. In September 1965, the department became the School of Public Health.[114]

1965: A School of Medicine was created at the University of Hawaii. The first class was admitted in September 1967.[115]

1966: Medicare, the federal program to provide basic hospital coverage and supplemental medical insurance coverage for persons 65 years old and over, was instituted in Hawaii on July 1.[116] Mrs. Tsuru Hirakawa, 71, was the first Island resident to be reimbursed under the medical care portion of the program on July 18.[117]

Transplants & Replants

1969: The successful transplantation of a human kidney in Hawaii was accomplished for the first time on August 10 at St. Francis Hospital in Honolulu. Similar operations occurred on August 13 and August 17. Though the first procedure ended in rejection, the second and third did not. The team was led by surgeon Livingston Wong and urologist Herbert Chinn.[118]

1974: On June 12, the Hawaii Prepaid Health Care Act was approved, to go into operation January 1, 1975. This legislation required employers to provide coverage under a prepaid health care plan for specified workers.[119]

1977: On December 23, Dr. James Doyle successfully replanted the severed thumb of Roy Campos Jr., a Kapaa rodeo rider who had lost it roping a steer at Kealia, Kauai. Although replants had been tried previously in Hawaii, this one, performed at The Queen's Medical Center, was believed to have been the first successful effort.[120]

1978: On March 31, 11-year-old Don Torres, who had developed aplastic anemia, was given Hawaii's first bone marrow transplant. The transplant team at St. Francis Hospital was headed by Livingston Wong.[121]

The first whole-body computerized tomography scanner in Hawaii was installed at St. Francis Hospital in May, and the first patient was scanned later that month.[122]

1979: On January 10, the first bone marrow transplantation for acute myeloid leukemia in Hawaii was performed at St. Francis Hospital.[123]

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Labor Under Ether: Hilo, 1850

A LETTER FROM CHARLES H. WETMORE, M.D.
ANNOTATED BY ROBERT C. SCHMITT*

On March 19, 1850, Dr. Charles Hinckley Wetmore, the missionary physician in Hilo, wrote to his colleague in Lahaina, Dr. Dwight Baldwin, to describe the birth of Mrs. Wetmore's first child a month earlier. This letter, previously unnoticed by medical historians, is of interest for several reasons: it not only provides insight into the perils of childbirth in 19th century Hilo, but it also appears to be the oldest surviving account of the use of anesthesia in the Hawaiian Islands.

The Wetmores had been married in Massachusetts on September 25, 1848, shortly before leaving for Hawaii. Charles Wetmore (1820-1898) was a native of Connecticut and a graduate of Berkshire Medical Institute in Massachusetts. Lucy Sheldon Taylor Wetmore (1819-1883), a native of Massachusetts, was "a tiny woman, weighing only 80 pounds when she was married," who "could walk under the arm of her 6-foot husband." The couple arrived in the Islands on March 11, 1849. Eventually they had five children, four of whom survived infancy.[1] Their oldest daughter, Frances Matilda, became Hawaii's first woman physician.[2]

Dr. Wetmore's casual reference to his use of ether suggests that general anesthesia was already well known in the Islands, but careful research has failed to uncover any earlier mention of the technique. William T.G. Morton, generally regarded as "the discoverer of anesthesia," had given a demonstration of the use of ether in excising a tumor of the neck at Massachusetts General Hospital on October 16, 1846.[3] News of this event had reached Honolulu on August 26, 1847, when The Friend carried an undated story from the Boston Journal reporting Morton's demonstration.[4] Ether was apparently introduced to the Islands sometime between August 1847 and February 1850.

References to anesthesia remained rare in Hawaii for several decades after Wetmore wrote his letter. On September 12, 1855, for example, Drs. Seth Porter Ford and William Hillebrand removed the entire left breast of Lucy G. Thurston because of cancer. In her harrowing account of the 90-minute operation, Mrs. Thurston noted, "Both doctors advised not to take chloroform because of my having had the paralysis."[5] This decision not to use an anesthetic implies its ready availability. In 1859, Dr. Gerrit Parmele Judd 'used chloroform successfully to deliver his first grandchild, William Chauncey ('Willie') Wilder."[6]

Writing in 1936, J.P. Rodrigues recalled working as a nurse at The Queen's Hospital from 1879 to 1882 and assisting Dr. Miner in operations. He noted: "Some of my work was to get the patients drunk, so they would not feel the pain so much, as we lacked anesthetics in those days."[7]

Dr. Wetmore's letter, apparently never before published, is in the collection of the Hawaiian Mission Children's Society Library. The Society's kindness in permitting publication of this letter at this time is gratefully acknowledged. An introductory paragraph of nonmedical comment has been deleted from this quotation:

Punahoa, Hilo, March 19th, 1850

"Dear Bro. Baldwin,

". . . It is now upwards of a year since we arrived at the Islands — never did a year pass apparently so rapidly with us until within a month of its termination — then the wheels of time seemed to roll slowly & heavily — before, we were healthy & cheerful & happy — afterwards, in pain & anguish and affliction. Mrs. Wetmore after a tediuous labor of 44½ hours gave birth to a little son (on the 16th ult.), whose weight was but 5 lbs. — the head was about the common size — but the body was small & slender — too frail to endure such a protracted labor — it had its mother's features and its mother's frame — with constant attention it continued to gasp at short intervals for an hour and then ceased to exist here, to go to take up its abode in a better home, where it will never know by experience what scenes of pain & sorrow & distress adult inhabitants of this world blighted with sin are from time to time called to

* State Statistician, Department of Planning and Economic Development.

Accepted for publication August 1980.

participate in. While we mourn under our affliction we also rejoice in the confidence we have that our little one is an angel babe, singing its innocent Hallelujah before the throne of our God of the Lamb — pray for us, that it may not be in vain that our Heavenly Father has placed us so early & so unexpectedly in the furnace of affliction.

"For several hours on Saturday morning (the day our babe was born) Mrs. W. seemed perfectly exhausted — pains subsiding &c. At this crisis, I administered the Ether — with the blessing of God upon its inhalation at intervals for upwards of an hour her strength returned & her pains became sufficiently vigorous to complete the process of parturition at evening. The secundines required a manual removal. She has been very feeble during most of the time since her confinement — but is now gaining rapidly — there is call for it — I can assure you — for she weighed only 79 lbs. last Saturday. She rode out for the 1st time yesterday — & has rode again today — enjoyed her rides much. She unites with me in sending much love to you & yours.

"We have heard indirectly that you are intending to visit Hilo soon. We hope to see you at our house — & if wife's health will admit of it (as I trust it will) we should be happy to welcome you to our little home to spend a part of the expected visit with us.

"I have written rather definitely to you in regard to [my] wife's confinement, because I thought you would be interested to know about it, having had your considerable practice in the obstetrical line.

"It is a time of pretty general health at Hilo & vicinity at the present time — fevers, of the Billious Remittent, — & typhoid type, & Influenza have prevailed to a wide extent during the winter months. We have had a good deal of pleasant weather as well as a good deal of rain since we came to Hilo — on the whole, are very much pleased with our location — love our home dearly.

"Ever & truly yours
Chas. H. Wetmore"

ACKNOWLEDGMENT

Thanks to the Hawaiian Mission Children's Society, 553 S. King Street, Honolulu, and to Mr. Oliver C. Deacon of Lakeport, California, great-grandson of Dr. Charles Wetmore, for permission to publish Dr. Wetmore's letter.

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3. Singer C and Underwood EA: *A Short History of Medicine*, 2nd ed. New York and Oxford: Oxford University Press, 1962, p. 344.
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6. Judd GP IV: *Dr. Judd, Hawaii's Friend*. Honolulu: University of Hawaii Press, 1960, p. 219.
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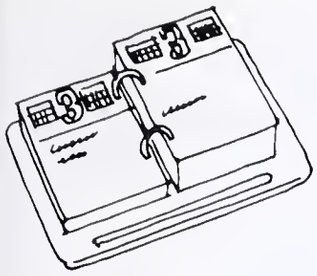
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Continuing Medical Education

CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G.N. Wilcox Memorial Hospital, First Thursday, 12:45 p.m. and Fourth Tues. 12:30 p.m. w/Maui Mem. Hsp. Held on Oahu at Am. Cancer Society main conf. room, 200 N. Vineyard, Honolulu.

John A. Burns School of Medicine

1. Dept. of Medicine
 - A. Case Conferences, Second and Fourth Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 - B. Grand Rounds, First and Third Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 - C. Endocrinology Grand Rounds, Third Wednesdays, 5:30-6:30 p.m., Queens University Tower, Room 506.
 - D. Hematology Grand Rounds, Second and Fourth Mondays, 12:30-1:30 p.m., Queens University Tower, Room 721.
 - E. Cardiology Grand Rounds, First and Third Tuesdays, 5:30-6:30 p.m., Queens University Tower, Room 508.
 - F. Infectious Disease Grand Rounds, Second and Fourth Tuesdays, 5:00-6:00 p.m., Queens Nalani I Conference Room.
 - G. Dermatology Grand Rounds, Second Wednesday, 7:30-8:30 a.m., Queens, Queen Emma Clinic.
 - H. Pulmonary Grand Rounds, Second and Fourth Thursdays, 4:30-5:30 p.m., Queens Kamehameha Auditorium.
2. Division of Nuclear Medicine
 - A. Technical aspects of Nuclear Medicine, Second Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506, 1½ credits.
 - B. Rounds, Fourth Wednesday, 5:00-6:30 p.m., Queens University Tower, Room 506.
3. Dept. of Obstetrics and Gynecology
 - A. Grand Rounds, Wednesday, 7:30-8:30 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
4. Division of Orthopaedics
 - A. Fracture Conference, Tuesdays, 5:00-6:00 p.m., Queens University Tower, Room 618.
 - B. Shriners Hospital Conference, Tuesdays, 7:15-9:15 a.m., Shriners Hospital.
5. Dept. of Pediatrics
 - A. Grand Rounds, Thursdays, 8:00-9:00 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 - B. Pediatric Conference, Mondays, 12:45-1:45 p.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 - C. Pediatric Infectious Disease Conference, Thursdays, 12:30-1:30 p.m., Kapiolani-Children's Medical Center, Third Floor Conference Room.
 - D. Neonatal Ground Rounds, Fridays, 8:00-9:00 a.m., Kapiolani-Children's Medical Center, Administrative Conference Room.
6. Dept. of Psychiatry
 - A. Grand Rounds, Fridays, 8:00-9:30 a.m., Queens University Tower, Room 618.
7. Dept. of Surgery
 - A. Grand Rounds, First, Second and Third Saturdays, 7:30-9:00 a.m., rotating hospitals.
 - B. Statistical M and M, last Saturday, 7:30-9:00 a.m., rotating hospitals.
 - C. Journal Club, First and Third Tuesdays, 6:00-8:00 p.m., Queens University Tower, Room 620.
 - D. Medical-Surgical G.I. Rounds, Second Tuesday, 7:00-8:00 a.m., Queens University Tower, Room 506.
8. Dept. of Family Practice
 - A. Conf., Wednesdays, 8:00-9:00 a.m., Kaiser 4th Floor Conf. Room.
 - B. Conf., Thursdays, 12:00-1:00 p.m., Kaiser 4th Floor Conf. Room.
9. Dept. of Physiology
 - A. Dept. Conf., Wednesday, 4:30-5:30 p.m., BioMed T-210.
10. University of Hawaii, John A. Burns School of Medicine Grand Rounds, Third Thursday, 4:30-6:00 p.m., Queen's University Tower, Room 618 or BioMed Building.
11. HI Oncology Group, one Monday a month, 12:30-1:30 p.m., The Cancer Center, 1236 Lauhala St., 4th Floor Conference Room.

Federation of Emergency Medicine-Maui

1. **Cardiology for the Emergency Physician.** Every Monday, 9:00-10:00 a.m.-Maui Memorial Hsp. Conf. Rm #1. (For spec. topics or further info. contact: Federation Office (808) 244-7629, or Dr. C.T. Mitchell, (808) 244-9056.
2. **Journal Club in Emerg. Medicine.** 2 hrs. Cat. I. MMH Conf. Rm. #1. 9:00-11:00 a.m.
 - 10/19/81 Annals in Em Med, 6/81; Abstracts in EM 7/81 - P. McCallum
 - 11/23/81 Annals in Em Med, 7/81; Abstracts in EM 8/81 - J. Mills
 - 12/21/81 Annals in Em Med, 8/81; Abstracts in EM 9/81 - C. Mitchell

Hawaii Thoracic Society

1. Pulmonary Med., Clinical case presentations & current research in pul. med. with U of H Sinclair Chest Club, Third or Fourth Wednesdays, each month, 7:30 p.m.-9:30 p.m. For further info contact: Rosemary Respicio, B.S.N. at (808) 537-5966.

Hickam Clinic

1. Clinical Correlation Conference, First Thursday, 11:00 a.m.
2. Didactic—our staff, Second Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, Third Thursday, 11:00 a.m.
4. Radiology Conference, Fourth Thursday, 11:00 a.m. (Contact Aurora Macapinlac, M.D., M.C., 449-5770)

Hilo Hospital

1. Orthopedic Conference, First Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m. Saturdays, 7:00-8:00 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, Second Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, Third Friday, 12:30-1:30 p.m.
5. C.P.C., Second Friday, 12:30-1:30 p.m.
6. Visiting Professor's Program

Kaiser Hospital

1. Medicine Grand Rounds, Every Tuesday, 8:00 a.m. Pac. Aud. 1 hr. Cat. I.
2. Tumor Board, Every Tuesday, 12:00 noon. Pac. Aud. 1 hr. Cat. I.
3. OB/Ped. Perinatal Mortality Conference, Last Tuesday, each month. 8:00 a.m. 1 hr. Cat. I.
4. Surg. Grand Rounds, Every Friday, 8:00 a.m. Pac. Aud. 1 hr. Cat. I.
5. Saturday Morning Educational Conference, Every Saturday, 7:30 a.m. Pac. Aud. 1 hr. Cat. I.

(Contact CME Dept.-Kaiser for further information)

Kapiolani-Children's Medical Center

1. Pediatric Grand Rounds, Every Thursday, 8:00-9:00 a.m., Aud.

2. Pediatric Conference, Mondays, 12:45-1:45 p.m., 2nd Floor Aud.
3. Neonatal Grand Rounds, Friday, 8:00-9:00 a.m., Conference Room B.
4. Pediatric Infectious Disease Conference, Thursdays, 12:30-1:30 p.m., 3rd Floor Conf. Rm.
5. Ob-Gyn Conference, Tuesday, 1:00-2:00 p.m., Aud.
 First—Didactic Presentation
 Second—Perinatal-Neonatal Topics
 Third—Obstetrics Topics
 Fourth—Gyn Topics
6. Tumor Board, Oncology Conference, First and Third Friday, 1:00-2:00 p.m., Aud.

Kuakini Medical Center

1. Department of Ophthalmology Mtg., First Tuesday, 12:30-1:30 p.m.
2. Department of Medicine Mtg. (Statistical), Fourth Tuesday, 1:00-2:00 p.m.
3. G.I. Conference, First Tuesday, 8:00-9:00 a.m.
4. Nephrology Conference, First Wednesday, 8:00-9:00 a.m.
5. Oncology Conference, Every Thursday, 7:30-8:30 a.m.
6. Pulmonary Conference. First Thursday, 1:00-2:00 p.m.
7. Surgical Conference, Second & Fifth Friday, 12:45-1:45 p.m.
8. Surgical M & M Conference, Fourth Friday, 12:45-1:45 p.m.
9. Department of Medicine Evening Mtg., Second Tuesday, 5:30-7:00 p.m.
10. Visiting Professor Program
 (for further info contact CME Dept. 547-9226 as these programs may be subject to change)

Maui Memorial Hospital

1. Thursday Conference, 7:00-8:00 a.m., Staff Dining Room.
 1st—Dept. of Medicine
 2nd—Dept. of Surgery
 3rd—Dept. of OB/GYN
 4th—Dept. of Pediatrics
 5th—Elective
2. Tumor Board, Every Monday, 12:15-1:15 p.m.—Tumor Conference Telephone Task Force—Third Tuesday, 12:15-1:15 p.m.
3. Dept. of Emergency Medicine, Third Monday, 7:00-8:00 a.m.
4. Diagnostic Radiology, Fourth Tuesday, 12:00-1:00 p.m.
5. SFH-UH Hematology Conf., Third Thursday, 12:30 p.m., Sullivan-4 Classroom.
6. SFH-UH Surgical Grand Rounds, First, Second & Third Fridays, 7:30 a.m., Sullivan-4 Classroom.
7. Visiting Professor Programs (for further info call CME office at St. Francis)

Hawaii Ophthalmological Society

1. Monthly dinner meeting, Third Thursday of each month. Contact: Dr. A. Kunimoto, (808) 941-2208.

The Queen's Medical Center

1. ENT Conferences, First and Second Fridays, 7:30 a.m., Small Dining Room.
2. Medical Conferences, Every Friday, 8:00 a.m., Kam Auditorium.
3. Ob/Gyn Conferences, Second and Fourth Mondays, 1:00 p.m., Kam Auditorium.
4. Ophthalmology Conference. Fourth Tuesday, 5:00 p.m., Queen Emma Eye Clinic.
5. Orthopaedic Conferences, Every Wednesday, 7:00 a.m., Kam Auditorium.
6. Pathology Conferences, Every Wednesday, 7:30 a.m., Surgical Conference Room.
7. Pediatric Grand Rounds, Fourth Thursday, 12:30 p.m., Nalani 1 Conference Room.
8. Surgical Trauma Conference, Second Tuesday, 4:30 p.m., Kam Auditorium.
9. Basic Science Lectures, Every Wednesday, 7:15 a.m., Queen's University Tower, Room 618.

St. Francis Hospital

1. SFH-UH Tumor Conference, Every Monday, 7:30 a.m., Sullivan-4 Classroom.
2. SFH-UH Nephrology Conference, First Monday, 1:00 p.m., Sullivan-4 Classroom.
3. SFH-UH Endocrine Conference, Last Monday, 12:30 p.m., Sullivan-4 Classroom.
4. EENT Meeting, First Tuesday, 7:00 a.m., Sullivan-4 Classroom.
5. SFH-UH Hematology Conference, Third Thursday, 12:30 p.m., Sullivan-4 Classroom.
6. SFH-UH Surgical Grand Rounds, First, Second & Third Fridays, 7:30 a.m., Sullivan-4 Classroom.
7. Visiting Professor Programs (for further info call CME office at St. Francis)

Straub Clinic & Hospital

1. Straub Professional Seminar meets the Second Tuesday of each month from 5:00-6:30 p.m. in the Credit Union Meeting Room (2nd Floor, Credit Union Bldg.).
2. Surgical Mortality and Morbidity Conference meets every Fourth Thursday of each month from 7:00-8:00 a.m. in the Doctors' Dining Room.
3. Cardiac Surgery Conference meets the Third Tuesday of each month from 4:30-5:30 p.m. in the Doctors' Dining room.
4. Department of Anesthesiology meets the Second Tuesday of each month from 7:00-8:00 p.m. in the Doctors' Dining Room.
5. Community Peripheral Vascular Conference meets the Fourth Thursday of each month from 5:00-6:30 p.m. in the Doctors' Dining Room.
6. Visiting Professor Program meets monthly from 7:00-8:00 a.m. in the Doctors' Dining Room.
7. Urology Inservice meets every other month on the Third Friday from 8:00-9:00 a.m. in the Doctors' Dining Room.
8. Neuropathology Clinical Correlation Conference meets the Third Thurday of each month from 7:30-8:30 a.m. in the Straub Morgue.
9. OB-GYN Pathology meets every Fourth Monday of each month from 12:30-1:30 p.m. in the Administration Conference Room (ACR).
10. Urologic Pathology meets every First Monday of each month from 8:00-9:00 a.m. in the Doctors' Dining Room.
11. Friday Noon Conference meets every Friday of each month from 12:30-1:30 p.m. in the Doctors' Dining Room.

*Note: All conferences are subject to change. Monthly calendar will be available upon requey.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. General Medical Staff Meeting, Quarterly in January, April, July & October.
2. Clinical Review Meeting, Alternate Mondays at noon.
3. Tumor Conference, First Thursday.

Miscellaneous

HMA Maternal and Perinatal Mortality Study Committee, First Monday each month-5:30 p.m. 320 Ward Ave., S 200. Cat. 1 on hr. for hr. basis.

SPECIAL EVENTS

Sept. 27-Oct. 3, 1981	Pacific Coast Obstetrical & Gynecological Mtg. Contact: Ralph Hale, M.D.; (808) 948-7457, J.A. Burns Schl. of Med., U of H Held: Kauai Surf.
Oct. 3 - 9, 1981	Operative Arthroscopy. UCLA. Contact: CCECS, 2530 Dole St., Honolulu 96822, (808) 948-8244. Held on Maui.
Oct. 7-9,1981	"Current Neurology." Straub Clinic & Hsp. Held: Honolulu Art Academy Aug. 900 S. Beretania, Honolulu. Contact: Off. of Med. Admins., Straub, 888 So. King St. Honolulu, 96813; (808) 523-2311.
Oct. 10, 18, 1981	Sixth Annual International Body Imaging Conference. West Park Hosp., 22141 Roscoe Blvd., Canoga Park, CA 91304. Held: Hyatt Regency Htl, Maui. Oncology Board
Oct. 12, 16, 1981	Oncology Board Review, Princess Kaiulani, ACP, Dr. Thomas Hall, Community Cancer Program of Hawaii, 1236 Lauhala, Honolulu 96813, (808) 548-8422.
Oct. 12, 16, 1981	AMA Regional & Scientific Mtg/HMA Annual Mtg. Held: Ilikai Htl, Waikiki. Contact: AMA Dept. of Mtg. Serv.; 535 No. Dearborn St., Chicago, IL 60610.
Oct. 12-16, 1981	Western Dialysis & Transplant Soc. Contact: Linda Huprich, Conv. Mgr., 1181 So. Los Robles; Pasadena, CA 91106. Held: Hilton Hawaiian Village, Waikiki, Oahu.

OUT OF STATE

For information on any out-of-state programs or courses, refer to September 3, 1980, Supplement to JAMA or call the HMA Office.



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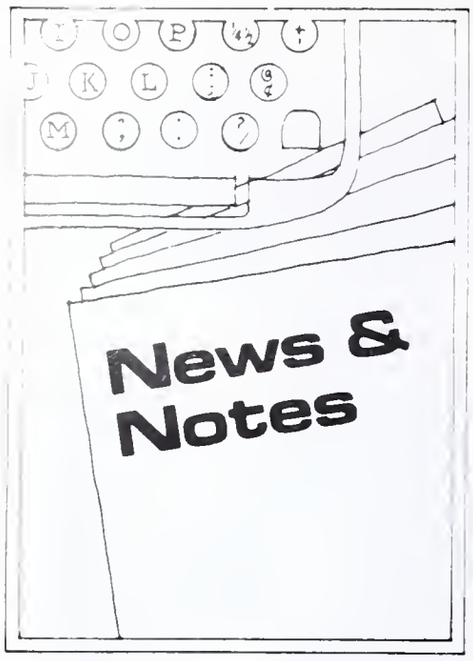
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HENRY N YOKOYAMA, M.D.

Professional Moves

Traditionally, the months of July and August are busy months for our homo sapiens medicus, but the anticipated flurry of activity is missing . . . In July, endocrinologist **S.Y. Tan** opened at St Francis Medical Office Building, Suite 206; cardiologist **Coolidge Wakai** moved to Suite 110, 1010 S King St; plastic surgeon **Michael Weiner** opened a new Kaneohe branch office at 46-005 Kawa St, Suite 307; and the Kuakini Radiology Group, Inc, added radiologist **Ted Watanabe**, whose subspecialty is neuroradiology. In West Hawaii, psychiatrist **A. James Morgan** opened at The Village Professional Plaza, 75-5759 Kuakini Hwy; and the Kona Medical Associates added pediatrician **Peter Locatelli**, general surgeon Dr **Pathomvanich**, and internist **P. Pathomvanich**.

In August, dermatologist **Norman Goldstein**, who fought so valiantly to preserve the Young Hotel Bldg and lost, relocated to the historic Stangenwald Building, 119 Merchant St, and the Kahala Mall Office Center, 4211 Waialae Ave. ER physician **Earl Kubota** joined the Straub Clinic and internist **Lance Kagihara** joined the Kalihi Medical Center. Pediatrician **Kenneth Siu** opened at the Professional Plaza of the Pacific, 1520 Liliha St, and bravely announced a 24-hour emergency service. Internist **John Berthiaume** joined the Straub Clinic at its Aiea office, 98-1247 Kaahumanu St, Suite 215 . . . From Don Chapman's column, we gleaned this item: "Orthopedic surgeon Dr **Roland Lichter** announced at this week's Honolulu Rotary meeting that he will be joining cardiologist Dr **Jack Scaff's** office at Kukui Plaza next month. The merger of the doc duo is an outgrowth of their jogging together for the past two years . . . "

Elected, Appointed, Honored . . .

Rheumatologist **Melvin Levin** won first prize from the Association Francaise de Lutte Antirhumatismale for a paper he presented at the 15th International Congress of Rheumatology in Paris. The Congress was held in June, and was attended by 3,000 rheumatologists from 30 countries . . . Over 1,100 papers were presented. Mel's paper described a program to improve the relationship between doctors and patients with rheumatoid arthritis. (From a six-year study including 50 patients)

Surgeon **Raymond Fujikami** was elected chief of staff and president of the St Francis Hospital executive board. Other officers are **Thomas Lau,** vice president; **Clifford Chang,** secretary; and **Edmund Lum,** treasurer . . . Raymond succeeded internist-allergist **Walter W.Y. Chang** . . .

Internist-oncologist **Quintin Uy** is one of two new members elected to the Disciplinary Board of the Hawaii Supreme Court. The board which oversees attorneys' ethics and discipline has a total of 18 members, including 14 lawyers and four non-lawyers . . .

Thomas Kosasa and **John Spangler** are board members of the Hawaii Planned Parenthood for 1981-82 fiscal year . . . Re-elected to the Honolulu Symphony Society board of governors are **Gerald Faulkner, K.Y. Lum,** and **William Won** . . .

"R.J. **Maffei** returned from Oklahoma where he judged sweepstakes at the Afghan Hound Club of America's National Specialty . . . " (Curious news item, eh?)

Life in These Parts . . .

The KMC dining room is where golfers congregate . . . Neurosurgeon **Max Urata** was relating how he had to admit a patient for a neurological workup after she had been struck on her head by her husband with a golf club . . . "What club did he use?" asked an anxious golfer . . . Max: "Probably a 5 iron or a mashie . . . " Another golfer piped up, "One should never use a golf club." Frank Fukunaga reassured him, "Well, if it's an old club, it should be all right."

David Pang did a thorough sports physicial on a high school student and found him to be an excellent physical specimen . . . David asked, "What position do you play?" "Quarterback," mumbled the athlete, then asked, "How tall am I?" . . . "You are 68 inches tall," replied David . . . "How many feet is that?" asked the quarterback . . . David: "You figure it out . . . How many inches to a foot?" "Well, doc . . . This is summer and we forget a lotta things . . . "

We noticed HLA2, our favorite editor-in-chief, sporting a right forearm cast, walking a mite stiffly . . . It seems that the day after Independence Day, he was horseback riding at 7 a.m., 3 miles up in Malaekahawe Valley . . . When he tried to lead his balky mount, it bucked and threw him. Poor Harry, he suffered a Colle's and verteral body compression fractures of T11 and S3 . . . (Dear Harry . . . This is the 2nd or 3rd time you've been thrown with disastrous results . . . The Journal cannot do without you, sir. Besides, who's gonna bail us out when we get into trouble writing this column . . . So please take up a safer sport such as swimming, brisk walking, etc, or get a mule . . .)

"DIS AND DOT: **Dr. Marquis Stevens,** who is retired after 40 years at Fronk Clinic, has just published a booklet on how to be a good partner at four-handed cribbage . . . " (From Don Chapman's July 17 column)

Jose Lee appeared with Martha Coleman, aquatic health and safety specialist, on a KNDI talk show to promote water safety and emergency preparedness. Jose reported that there is increased sunspot activity this year, increasing the risk of sunburn and skin cancer and, also dangerous, high surf . . . During the first seven months of this year, 33 persons have drowned in Hawaii, a rate higher than in previous years

"Honolulu price index nosedives to 6.8 percent for April to May." The 1980 CPI for Honolulu was 9.9 percent. Medical cost were up 2.2 percent from April to June and the U.S. Bureau of Labor Statistics singled out higher prices for health insurance and hospital rooms. Medical care costs are up 11.7 percent from June 1980.

"While knocking about Pokai Bay in an inflatable dinghy, skipper Andy Jones hit a coral head and gashed the bottom of the rubber boat . . . Dermatologist and cosmetic surgeon **Bruce Chrisman** repaired the damage and afterward everyone aboard agreed that the boat suffered no residual scars. Even better, the dinghy now 'looks 10 years younger.' " (From Don Chapman's August 10 column)

Do we get that creepy feeling that Big Brother is watching? Hawaii's Medicaid Fraud Unit has entered its fourth year of operation with 100 percent success in obtaining fraud indictments and sizable civil recoveries of funds . . . **Patrick Border,** chief of the unit, says, "We never take a case unless we think we can prove it, but even if we lose it outright, from my standpoint every day we spend in court is a win . . . Fraud prosecution is a slow and frustrating process . . . The main claim they have is that it was an accident . . . Maybe it was an accident . . . and they may be just as surprised as anyone and correct the matter . . . Any name can pop up once, but if it pops up twice in a different context, we might take a closer look . . . " The Wong and Dickie cases make a total of seven indictments for the unit since it was formed in July 1978.

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Miscellany . . .

There was a young man from Bombay,
Who thought syphilis just went away,
And now he has tabes
And saber-shinned babies,
And thinks he's the Queen of the May . . .

(Submitted by **Doris Jasinski**, our dear managing editor, in an effort to "clean up Henry's Column.")

Interesting philosophy in this bumper sticker: "Beat the heat . . . Go to Heaven."

Summer Meeting

Hawaii Society of Pathologists Summer Meeting, Makaha, July 24-26:

Slide Seminar dialogue:

Our favorite humorist from Maui, **Cliff Moran,** presented two cases . . . One was a 38-year-old Hawaiian man with neurofibromatosis and a 2-week history of a large Rt flank mass, which, on exploration, rose from the retroperitoneal space. The gross specimen measured 30 cm across and consisted of necrotic tissue with scattered solid tumor . . . Referring to an earlier case presentation from Kaiser pathologist **Stanley Loo,** Cliff commented, "I must congratulate Dr Loo on his diagnosis of interstitial cell tumor from frozen sections . . . Apparently they do this routinely at Kaiser, but at Maui Memorial, we don't do this as a routine . . . Anyway, the patient had neurofibromatosis and two other family members also have neurofibromatosis, so I called it malignant Schwannoma, even though it looked like leiomyosarcoma . . ." QMC neuropathologist **Hideki Namiki** disagreed with Cliff . . . "I called it malignant histiocytoma, even though the patient has neurofibromatosis . . . " No one disputed either opinion and thus it stood . . . Pathologists frequently do this, as you well know . . . We feel it is out of respect for each other and a healthy form of confrontation . . .

Cliff's second case was a 67-year-old woman with two bouts of pancreatitis . . . Studies showed a 3.5 cm mass in the body of the pancreas which Cliff felt was a pseudocyst . . . Cliff reported caustically, "We called it a benign cyst on frozen so the surgeon went ahead with a Whipple . . . Permanent sections showed a cystadenoCA, but personally I think this is a benign tumor and I am sure the woman is cured . . . You see, at Maui Memorial, we do a Whipple right away . . . We don't bother with stuff like permanent sections . . . "

After his two case presentations, Cliff, in a more solemn vein, announced that this may be his last presentation at these meetings . . . At age 64, the staff at Maui Memorial had voted 68 to 8 to retire him . . . "Now if this happened at Kuakini, there would have been 99 votes against and only 1 for Stemmy (Kuakini pathologist **Grant Stemmerman**, who is known to be equally adamant and vocal in his opinions) . . . The one vote would come from **Henry Yokoyama** because without Stemmy, Henry won't have anything to put in the Journal . . . " So into retirement goes another of the true blue breed of pathologists whose witty, often abrasive comments could be sheer poetry . . . They were a breed unafraid to call a spade a spade and in whose wake physicians who showed poor judgment were openly castigated . . . We are sorry to see Cliff retired but we are quite confident that Cliff will once again ride forth on his white charger from his Kihei beach home . . .

During the intermission, we spoke to **Jim Bennet,** retired Kaiser pathologist, who ran the last marathon with his daughter and 13-year-old granddaughter (a three-generation run). Jim is thinking of lifting weights because people are commenting about his haggard look . . . We reassured him that he certainly looked less haggard now than he did three or four years ago and that it was not a haggard look, but the "lean" look we see on all runners . . .

Tom Kohara looked at **Herb Uemura,** another jogger, and commented, "I told Herb that he had the jogger's syndrome . . . i.e., they're lean, they only talk about exercise and health, and they suddenly become a big bore at nine in the evening . . . "

QMC pathologist **Takushi Hayashi** discussed the case of a 70-year-old retired electrician who had worked at PHNY for 30 years. A thoracotomy revealed a nodular cauliflower-like lesion, which, on tissue section, was malignant mesothelioma. Takushi showed asbestos bodies from the pleura and lung biopsies, and reported that each asbestos body correlates with 3,000 asbestos bodies per gm of tissue. He had "digested" 2.2 gms of tissue and found 177 asbestos bodies . . . Someone asked, "So you can say that this tumor was caused by asbestos." Takushi quickly responded, "No . . . I have carefully avoided answering that question . . . "

We were simply enthralled by the descriptive terminology, . . . e.g., an interstitial Leydig cell tumor was described by **Stanley Loo** as a "mildly bosselated tumor nodule with light golden tan fleshy cut surface . . . "

The Saturday night banquet was MC'd by outgoing president **Rex Couch.** After briefly touting "Dr Couch's Facial Sunscreen" (we missed the point of his remarks), he continued, "I'm in a quandry . . . I've only had six weeks to prepare and I have no new golf jokes . . . but there are a couple here in the audience . . . And no new tennis or pathologist jokes . . . I thought and thought and finally remembered a joke told by my dear father-in-law . . . a true-to-life personal experience. He was the new proctologist in a Midwestern town and stepped into the bar for a drink . . . The town hussy, who had had a few drinks, asked the bartender, "Who's that beautiful man . . . " The bartender informed her that he was the new proctologist in town . . . "I must get to see him," she titilated and forthwith made an appointment. When my father-in-law came into the examining room, she was jacknifed on the procto table . . . "What is your trouble?" he asked . . . "Oh, doctor," she gushed, "I've been so constipated . . . Can you help me?" One look and he exclaimed, "No wonder you are so constipated . . . You have all those roses showing . . . " "Oh doctor!" she touted happily, "Read the card! Hurry, read the card!"

Golf tournament chairman **Frank Fukunaga** announced the jackpot winners and that the tournament chairman for the next meeting will again be **Tom Kobara,** assisted by **Jim Navin** . . . Tied for second place were **Paul Sunahara, Garth Morimoto,** and **Masaru Koike**. Third place was **H. Yokoyama** . . .

Jim Bennet announced the tennis tournament winners, who were practically all members of the tennis-playing **Young Paik** family . . . except for Jim's wife, Jean, who won first place. "It seems that all my teaching has finally paid off," he said modestly . . . Jim was in third place and **John Wellington** was happy with his fifth place prize (a King's Bakery sweet bread and a Hawaiian Airlines tennis cap). Jim told his taxidermist joke: "A sentimental spinster had two pet monkeys she adored . . . They both died from some mysterious malady and the spinster was grief stricken . . . She took the two bodies to the town taxidermist, who asked, "Do you want them mounted?" The spinster blushed a vermillion red, "Oh, heavens, no! Just have them holding hands . . . "

Finally, Rex anounced that next year's president was **Judith Bigley** and acknowledged, "This smooth running annual meeting is due to Godfather **Herb Uemura** and his wife, Jane . . . " Herb has been the perpetual program chairman not only for the HSP, but for the HMA as well . . . And it certainly was time someone gave him credit for all the extra time he has to put in . . .

Oncology Dialogue . . .

A 67-year-old Japanese male has multiple cancers . . . He has early gastric CA, an invasive epidermoid CA of the hypopharynx, and an invasive ductal CA of the breast. It was a question whether his bone and lung metastases were from the breast or the hypopharyngeal primaries . . . Oncologist **Noboru Oishi** asked, "Has he had a CT scan? This fellow is quite robust in spite of his cancers . . . " Radiotherapist **Carl Boyer** was cautious, "If we do, we may find more cancers . . . With the hypopharyngeal CA alone, if it is T3 or T4, he has a 10 percent chance for survival . . . "

Surgeon **Glenn Kokame** described another case of multiple cancers. A 57-year-old multiracial man from Waianae had a total pneumonectomy in 1975 for adenocarcinoma of the Rt lung. **Ed Quinlan** did the radiation therapy radiation . . . Two years later, the patient developed laryngeal carcinoma and had a laryngectomy by ENT man **Gene Doo.** Another two years later, he developed cancer of his Rt breast and Glenn removed it surgically . . . More recently he developed a Lt supraclavicular tumor which was completely excised through a Lt axillary approach . . . Glenn showed a recent color photograph of his patient, smiling happily and looking quite hale and hearty, despite a chest wall cross-hatched with surgical scars . . .

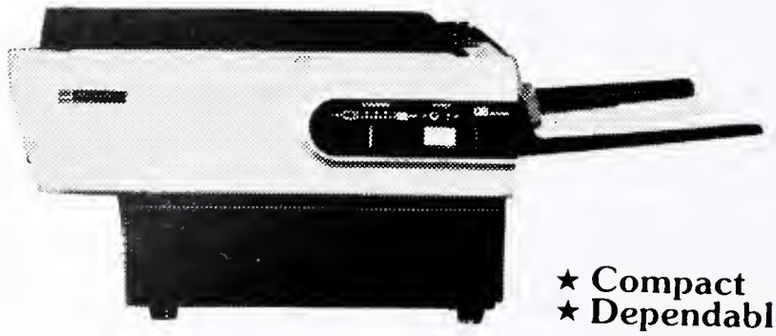
Miscellany . . .

The man strolled into the bar with a gorgeous woman holding onto his arm . . . "Bartender, let me have two beers . . . " The bartender placed two glasses of draft beer before them . . . A little elf, perched inconspicously on the man's shoulder, walked down his arm and knocked down the two beers . . . The bartender saw this, but kept his cool. The man ordered two more beers . . . Again the little elf ran down his arm and knocked down the two tins of beer . . . The bartender was furious . . . "I'll call the cops . . . Why don't you get rid of the guy . . . " The man said, "Never mind, I'll pay for all the beers . . . Just get me two more beers . . . " The bartender said, "If you don't tell me what's going on, you don't get any more beers . . . " "Well," said the man, "I was rummaging through the Kailua dump when I found this odd-shaped bottle . . . When I removed the cork, out popped a genie who gave me three wishes . . . So, I first wished for the most gorgeous gal in the world . . . And if you peek out your door, you can see my Excalibur . . . My final wish was for the world's biggest prick . . . " "What happened?" asked the bartender . . . "Well, that's him perched on my shoulder . . . " (As told by **Dennis Lind's** wife, Judy)

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HMA Auxiliary

The Auxiliary to the Honolulu County Medical Society is convening its Annual Guest Day Program at the Hibiscus Ballroom of the Ala Moana Hotel on November 5, 1981. The theme is "Ethno-Medicine: Crossing Cultures to Improve Health Care."

Keynote Speaker is **Senator Pat Saiki**, Chairman of the Senate Higher Education Committee. Conference Day Chair is **Dr. Ann Catts**, President-elect of the Hawaii Medical Association. Some of the other distinguished speakers and panelists are: **Dr. Victor H. Li**, President of the East-West Center; **Dr. Donald Char**, Student Health Services; **Dr. Neal E. Winn**, President of the Hawaii Medical Association; **Dr. Daniel S. Sanders**, Dean of the School of Social Work; and **Dr. Mary Amundson** from the School of Nursing. Concerns of the community will be expressed by **Mr. James Swenson**, **Mr. Albert Yuen**, **Ms. Ah Quon McElrath**, and many others.

The Program seeks to explore the role of language and cultural understanding in health care and the responsibility of the education community in its training of future health care workers. The Program is co-sponsored by the University of Hawaii. Other co-sponsors are welcome. Conference chairman is **Priscilla Ching Chung**; Co-chairman is **Sharon Morton**. Accreditation for the Program will be pursued by members of the Guest Day Committee. Estimated cost of attendance is $10 per person. For further information, contact: **Dr. Priscilla Ching Chung**, Office of the President, University of Hawaii, 2444 Dole Street, Honolulu, Hawaii 96822.

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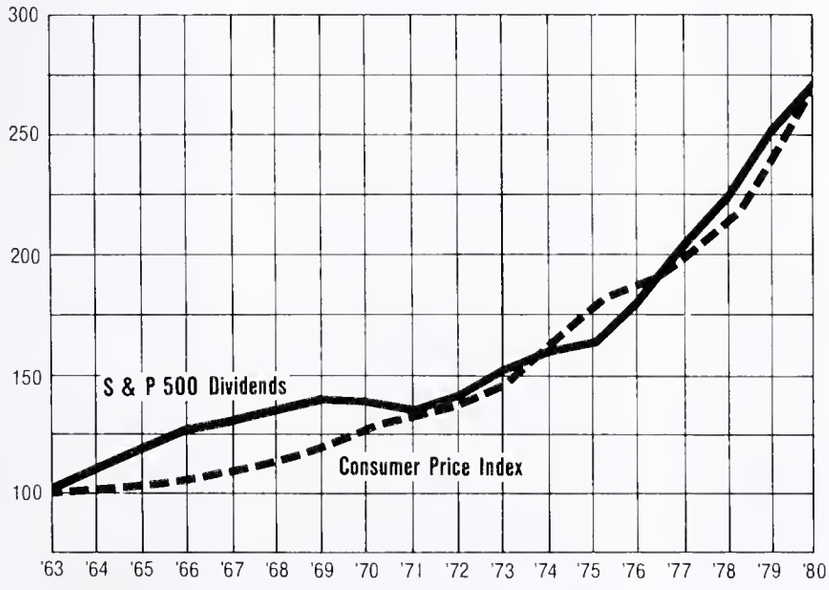
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Inter-Island Nurses' Bulletin which was published in *Hawaii Medical Journal* until volume 21, issue 3, January-February 1962, was indexed selectively.

Hawaii Technologists' Bulletin was published in the *Journal* from volume 17, issue 6, May-June 1970, and was not indexed.

We would like to acknowledge the assistance of the entire staff of Hawaii Medical Library in the preparation of this index.

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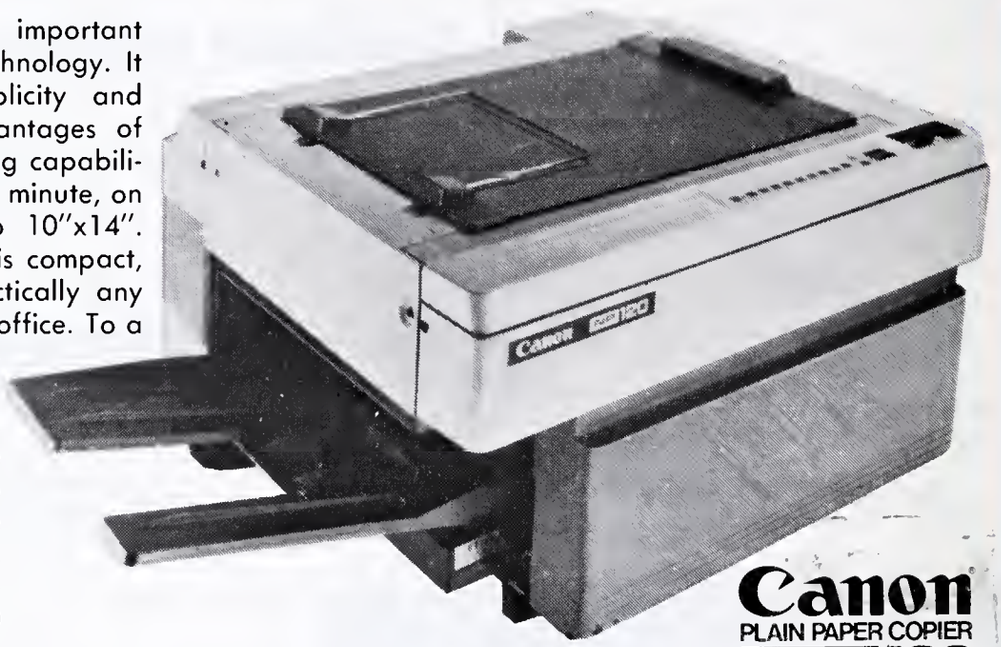
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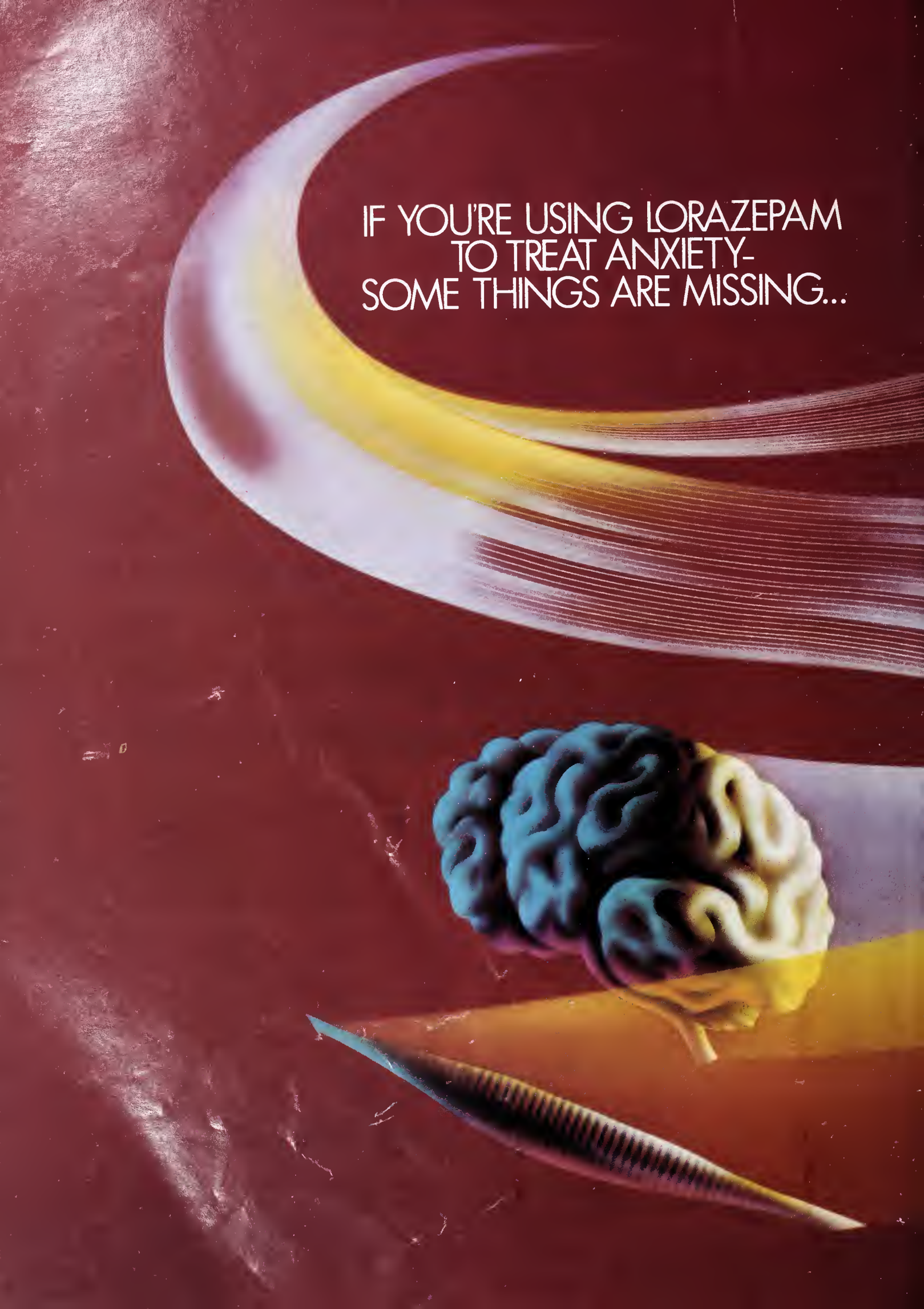
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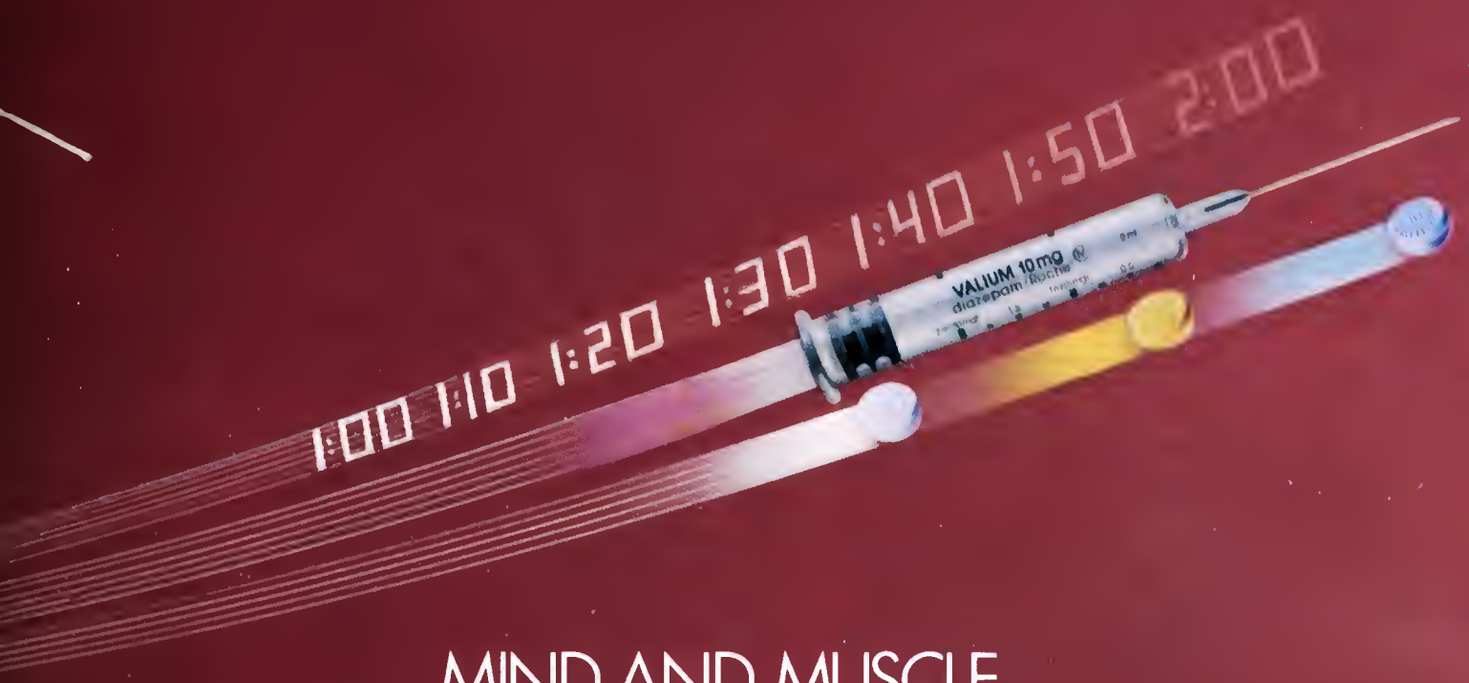
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References: 1. Data on file, Hoffmann-La Roche Inc. 2. Seppala T, *et al: Br J Pharmacol* 3:831-841, 1976. 3. Harry TVA, Richards DJ: *Br J Clin Pract* 26: 371-373, 1972.

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The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.
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Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.
***Usage in Pregnancy:* Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**
ORAL: Advise patients against simultaneous ingestion of alcohol and other CNS depressants.
Not of value in treatment of psychotic patients, should not be employed in lieu of appropriate treatment. When using oral form adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.
INJECTABLE: *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling, and, rarely, vascular impairment when used I.V.: inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins, i.e., dorsum of hand or wrist, use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*
Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least ⅓; administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs. Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status. Not recommended for OB use.
Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence, can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.
Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of Valium (diazepam/Roche), *i.e.*, phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed or tolerated).
The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.
INJECTABLE: Although promptly controlled, seizures may return; re-administer if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic; have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.
Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug.
Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, have been observed in patients during and after Valium (diazepam/Roche) therapy and are of no known significance.
INJECTABLE: Venous thrombosis/phlebitis at injection site; hypoactivity, syncope; bradycardia, cardiovascular collapse; nystagmus; urticaria, hiccups; neutropenia.
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Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure, employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension. Dialysis is of limited value.

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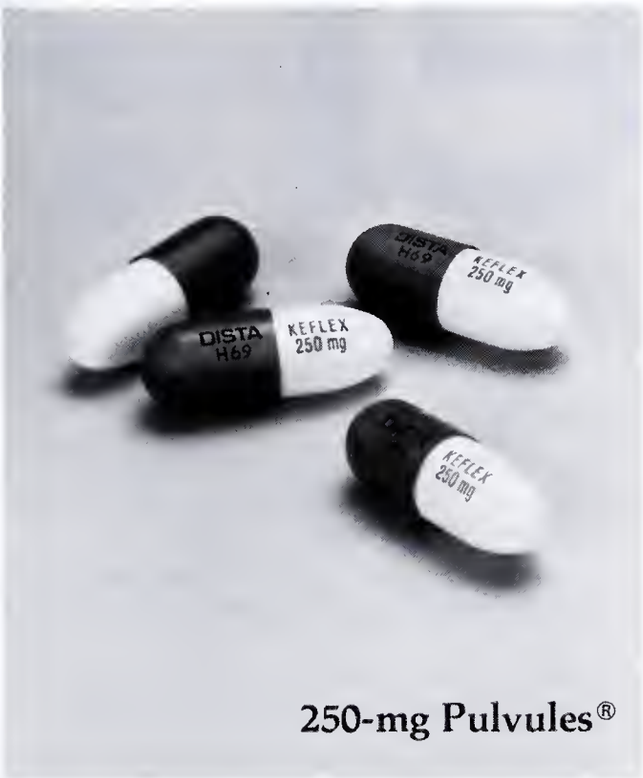
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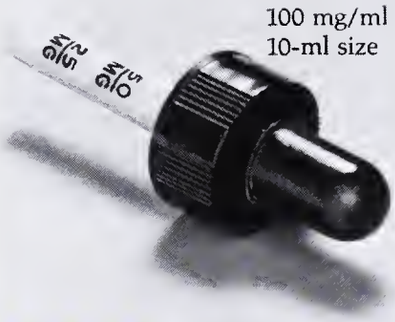
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Editorials

Doctor in Wonderland

"Everything is queer today." — Alice

We just received a clipping that announced a woman in the community was to receive her doctoral degree in "Medical Astrology" soon. She anticipated being able to bring the best of both these related fields to bear upon her clients' illnesses, despite what seemed a clear contradiction in terms.

Recent pronouncements by the California Board of Medical Quality Assurance (BMQA) that nurse practitioners, mid-wives, and other non-physicians should have the same hospital admitting privileges as physicians seem certain to promote just the opposite of "medical quality assurance."

Meanwhile, the BMQA has withdrawn from the Federation of State Medical Boards, and will hold hearings which could remove all licensure from physicians. At issue is the proposal that in a true democracy, *anyone* should be allowed to practice medicine and have access to all but controlled drugs.

Now comes the Omnibus Medical Reconciliation Act of 1980, in which podiatrists have been transformed into "Doctors of Podiatric Medicine" for federal programs, and henceforth are considered "physicians" for Medicare purposes, including serving on hospital utilization review committees, certifying disease, etc. The same magic wand effect may soon apply to "Doctors of Chiropractic Medicine," "Optometric Medicine," etc.

And the California State Employees Association, representing hospital employees, recently laid such gems as ". . . it is the team, not the doctor, that has the decision-making authority in patient treatment," and ". . . the doctor, as a member of the treatment team, shares an equal voice in the decisions that are made . . . " Treatment *team*?

"The trouble with you doctors," the lady told me reproachfully, "is that you just don't keep up with the latest scientific advances like magnetism, pyramid energy, colon therapy, and stress-analysis, to be able to truly help your patients!" Alas, I'm afraid I'll *never* know enough about magnetism to benefit my patients, or medical astrology, either.

Lately, I'm having the same problems with reality testing that Alice was having:

"There's no use trying," she said. "One can't *believe impossible things."*

"I daresay you haven't had much practice," said the Queen.

JMC

Goodbye, Paul — Hello, Doris!

Executive Editor Paul Steward resigned last spring after shepherding the JOURNAL through years of slowly declining advertising revenues that very nearly culminated in our being discontinued this year by the HMA Council. It would have ended almost 40 years of continuous publication. Mr. Steward did a complicated job with little apparent effort and most remarkable skill, and he left the position with regret on both sides.

Now production of the JOURNAL is in the hands of our new managing editor, Doris R. Jasinski, M.D., who has been associate editor for the past 18 years. Dr. Henry Yokoyama continues as news editor, and Dr. John Corboy as associate editor. Dr. Fred Reppun has returned to our staff as associate editor.

Crossroads Press has become our publisher and advertising manager, retaining advertising fees to offset publishing costs.

Old features are being continued, and one new one, Over the Editor's Desk, has been added; it will offer capsule summaries of new products being offered and occasional "pearls" from medical publications. Look for it among the ads.

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Adolescent Psychiatric Hospitalization and Ethnic Origin: Hawaii 1979

Stephen S.F. Choy, Ph.D.*

• *This study was conducted to examine the representativeness of the various ethnic groups among the adolescent residents of the Hawaii State Hospital. Age, admitting diagnosis, source of referral, and age by diagnosis have been tabulated annually, but there has been no known examination of ethnic factors. It was hypothesized that the ethnic extractions of Adolescent Unit residents would mirror those of the general adolescent population of Hawaii.*

There were 66 admissions to the Adolescent Unit during the year 1979. Seven persons had multiple admissions that year, but were counted only once. Each adolescent was assigned to an ethnic group representing a "pure" race. The exceptions to this rule included the following: Pure and part-Hawaiians comprised one category. "Caucasians" (persons of European ancestry) were an independent group, assuming no admixture of any other race. "Other" included Chinese, Samoan, Korean, African, and persons of mixed race. The reason for combining the last groups was the small number of adolescents represented. The 5 ethnic categories were Caucasian, Japanese, Hawaiian/part-Hawaiian, Filipino, and Other. Base rates for the various ethnic groups were obtained from the 1979 Health Surveillance Program of the Department of Health. A 2x5 design invcstigated sex by ethnic origin, and chi square analyses were performed on the data.

TABLE I
1979 Adolescent Unit Census

Ethnic Category:	Boys:			Girls:			Total:		
	O	E	X^2	O	E	X^2	O	E	X^2
Caucasian	17	6	20.17**	7	6	.16	24	12	12.00**
Japanese	1	7	5.14	0	5	5.00	1	12	10.08*
Part-Hawaiian	17	10	4.90	6	9	1.00	23	19	.84
Filipino	4	4	0	5	3	.33	9	7	.00
Other (including Chinese, Samoan, Korean, & Mixes)	8	9	.57	1	7	4.00	9	16	3.06
			**			**			**
			30.78 (df=4)			10.49 (df=4)			25.98 (df=4)

* $p < .05$
** $p < .01$

Results

When ethnic groups were compared (Table 1), Caucasian and Japanese groups were significantly different from the expected, judging from base rates. No other groups achieved significance.

Looking at the factor of sex, Caucasian males were significantly different from the expected ($p < .001$). No other groups demonstrated sex differences.

Among the Caucasian group as a whole (Table 2), nearly half these adolescents were military dependents, determined by eligibility for CHAMPUS benefits. This suggests that being "military" contributed greatly to the Caucasian group's significantly higher representation, when compared with the expected from population base rates. A chi square analysis was performed, comparing observed

TABLE II
Caucasian Group

Both Sexes			Statistical Tests
(N=24)	O	E	
Military	11	5	$X^2=9.1$
Civilian	13	19	df=I
			$p < .0I$
Males			
(N=17)	O	E	Binomial Test
Military	8	3	p=.01
Civilian	9	14	
Females			
(N=7)	O	E	Binomial Test
Military	3	2	N.S.
Civilian	4	5	

military and civilian Caucasian adolescents with their expected numbers, and based upon 1979 Health Surveillance Program data. Military Caucasian adolescents were found to be significantly over-represented ($p < .01$) when compared with their civilian counterparts.

While all military-dependent Caucasians were noted to have significantly higher representation than civilian Caucasians, male, military-dependent Caucasians were especially implicated (Table 2). Separate binomial tests for boys and girls showed that only male, military-dependent Caucasian adolescents where over-represented, compared with their civilian Caucasian adolescent counterparts ($p=.01$)

Discussion

Statistical analysis revealed the Caucasian and Japanese groups to be significantly different from other ethnic groups represented at the Adolescent Unit. When base rates are considered, Japanese adolescents are underrepresented. Male, military-dependent Caucasian adolescents, on the other hand, are highly over-represented.

Little is known why Japanese adolescent admissions are so low. Gudeman[7] suggested that for the Japanese there is

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* Clinical Psychologist, Adolescent Unit, Hawaii State Hospital
Presented at the Hawaii Psychological Association Convention, 1980.

a greater stigma associated with mental illness. Examining the topic of chronicity among Hawaii State Hospital patients, Gudeman[8] noted the high frequency of Japanese among the long-term population. He attributed the Japanese over-representation to the stigma attached to mental illness in this ethnic group. He reasoned that the greater significance of mental illness and consequent ambivalence "function to help the Japanese patient remain hospitalized to the point of chronicity."

While this is not the case among Japanese adolescent patients, the perception of stigma associated with psychiatric hospitalization may still apply. If local Japanese give greater emphasis to appearance than do other races, as Gudeman suggests, it may be that families function to care for their own disturbed members as long as they can. Only when this is no longer possible, and, especially for severely disturbed members, does the family resort to long-term hospitalization. Significantly fewer Japanese adolescent admissions, therefore, may be due to the fact that Japanese families tolerate greater deviancy in their disturbed adolescents than do families of other races. Psychiatric hospitalization is considered only as a last resort.

Military Families

The scant literature regarding the military family supports the contention that dependents of military personnel, especially children, generally demonstrate behavioral disorders more commonly than their civilian counterparts. Bey and Lang,[1] Cretekos,[4] Crumley and Blumenthal,[5] Gonzalez,[6] MacIntosh,[13] and Pearlman[14] have written of intrapsychic conflicts in the wives and children of military fathers, absent because of service obligations. These dependents experienced grief reactions, anger, mourning, and guilt. Enforced family separations were said to alter the personality development of children, especially with regard to superego formation and object relation. Bloom[2] and Crumley and Blumenthal[5] compared military and civilian psychiatric patients, finding 24% of the former versus 16% of the latter demonstrating behavioral disorders. Among the military patients, two-thirds had histories of father absenteeism.

Lagrone[12] reviewed the case records of 792 children and adolescents referred to a military clinic in the Midwest over a span of 2 years. When compared with data from a civilian mental health clinic, the diagnosis of behavioral disorders was made more frequently in the military clinic. Of the military cases reviewed (N=792), 32% were diagnosed as being behavior disorders, while 28% were reported as being transient situational disturbances. Figures for the civilian group, however, were not cited. In the U.S., it is estimated that 10% to 12% of the general population of children have emotional problems and require treatment (Coleman[3]). In Lagrone's study, 12% of the families on a base were evaluated over a 2-year period, more than 94% being families of enlisted personnel.

Seven problem areas were delineated by Lagrone, many of which were common to all referrals and almost universally noted in those diagnosed as behavioral disorders. The problems included the relationship the father had with the military, father's absence, transiency, child-rearing methods, scapegoating, the husband-wife relationship, and resistance to treatment. Briefly stated, a strong alliance is formed between the father and the military, with the family assuming a subordinate place. As "outsiders" or "dependents," they qualify for base privileges only insofar as the father is on active duty or alive. In response to their inferior status, the family may withdraw from him out of necessity and anger, and mutual feelings of rejection may be experienced. The father grows to rely more and more upon the military for support, while the family turns to itself more as a means of survival.

Johnson and Szurek[10] used the term "acting out" to describe a process which may be related to the strategy used by these families. In order to elicit greater involvement of the father in family matters, the mother may exaggerate the misbehavior of the children and, perhaps, even covertly endorse delinquent behavior. Such factors may be related to the inordinately high number of Caucasian military-dependent males admitted to the Adolescent Unit in 1979.

One study of the child in the military community provided typical results. Kenny[11] compared children from military and civilian communities with regard to intellectual functioning, emotional adjustment, and occurrence of juvenile delinquency. A total of 206 children, between the ages of 10 to 15, were selected from approximately 2,000 children residing in a military housing area in Wiesbaden, Germany. The experimental group consisted of 86 children referred by the school or pediatric clinic for psychological reasons. The controls consisted of 20 children, each from grades 5 through 10. All of the participants were diagnosed on a adjustment-maladjustment continuum by 3 psychiatrists who had access to the children's records. Surprisingly, military children had a higher median IQ and a better record of academic achievement. The percentage of military children requiring psychiatric treatment was only 3% versus 9% to 10% in the civilian community. The juvenile delinquency rate among military children was 1.5%, as opposed to 4.1% for the U.S. population as a whole.

Kenny believed that the differences he found were attributable to the fact that the military is a select community. He cited President Johnson's statement in January 1964 that approximately 50% of those eligible for the military draft were rejected. Among the primary reasons for rejection were intellectual and emotional defects. Furthermore, Kenny reasoned, because education has been given such great emphasis in the military, more highly trained personnel have been the result. As such, military personnel have been a more select and better educated group, qualities which are also reflected in their children.

Kenny's study provided results which contradict Lagrone's findings and those of this study. As he points out, his population was more select than the general population of the United States. Since 1973, however, the draft was abolished and a volunteer army instituted. It is very likely that, at present, the military more closely resembles the general population, and other factors, e.g., economic, have impinged upon military families that were less prominent in 1963 when Kenny collected his data. Furthermore, his sample represented a military population sta-

tioned in a foreign country, rather than in the U.S. where Lagrone's and this current study were conducted. Exactly what impact this factor contributes, however, is not known.

Admittedly, the foregoing represents post hoc commentary on possible reasons for the obtained results. Like most studies, more questions were raised than answered. It remains for future research to support or refute the hypotheses contained herein.

Summary

Sex and ethnic origin of adolescent residents of the Hawaii State Hospital were examined. Using chi square analyses and statistics from the 1979 Health Surveillance Program, it was discovered that the Caucasian and Japanese adolescents were significantly different from other ethnic groups. It was demonstrated that Japanese adolescents were significantly under-represented, and male, Caucasian adolescents significantly over-represented. A closer analysis revealed male, military-dependent Caucasians, in particular, to be significantly dissimilar from other groups.

Available literature suggested the following factors may be relevant: For Japanese, because appearances are so important, the stigma attached to mental illness acquires greater meaning than for other races. Japanese families may care for their disturbed members as long as possible. A point is reached, however, when the disturbed member becomes a burden for the family and is turned over to the State Hospital, where chronicity becomes manifest.

The male, military-dependent Caucasian adolescent was especially prominent in this study. Research suggests a "military family syndrome," engendered by the father's absence from the home. A loyalty bind is created when the father pledges his allegiance to the military. Wives and children vie for his time and attention, often colluding to exaggerate the children's misbehavior.

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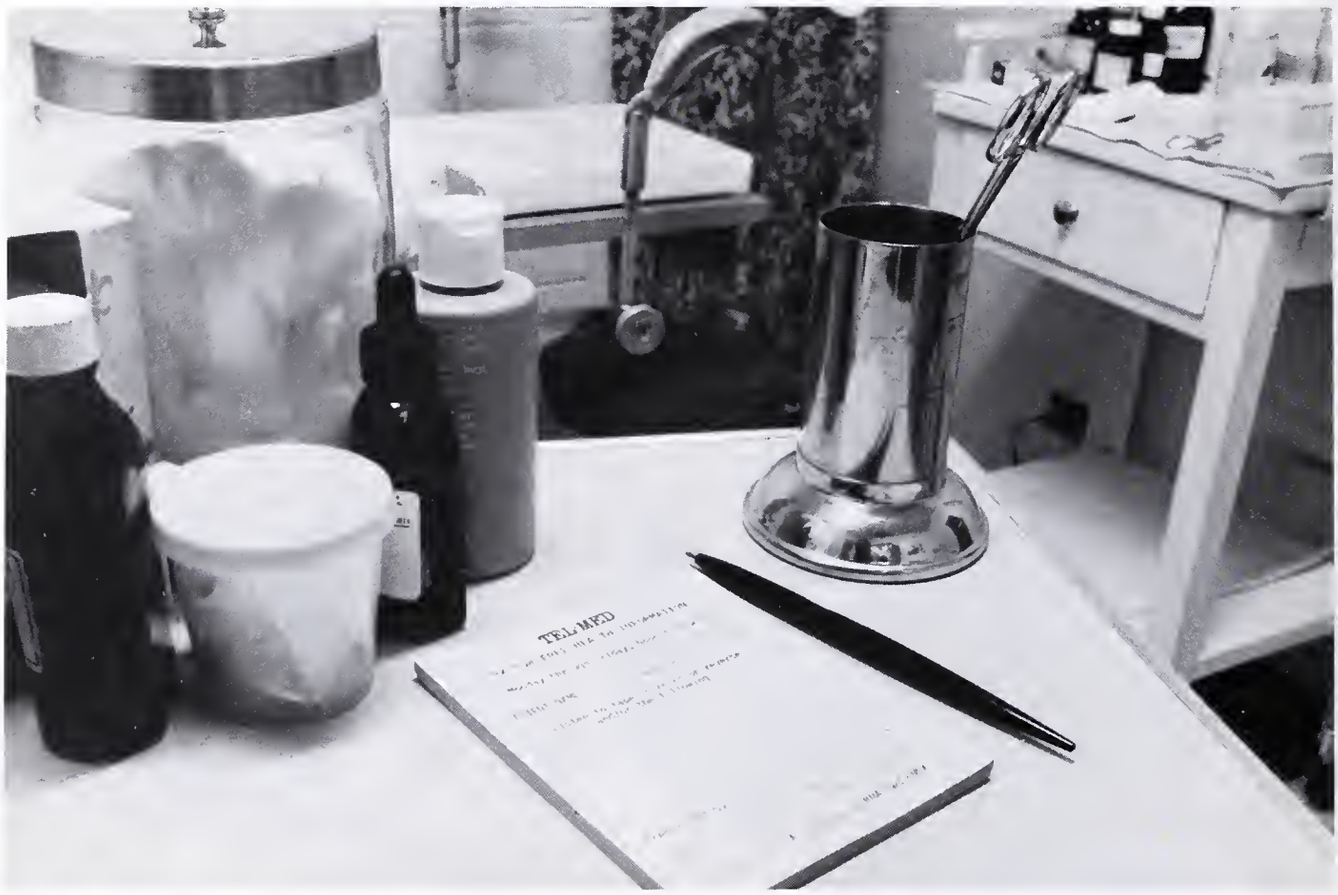
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Aquatic Medicine in Hawaii

Kenneth W. Kizer, M.D., M.P.H.

Hawaii is blessed with abundant sunshine, spectacular scenery, sparkling ocean waters, and a verdant marine environment. It is no wonder, then, that it has become a mecca for water sports enthusiasts of all kinds. In fact, few places in the world have the diversity and intensity of aquatic recreation and industry as does Hawaii. Unfortunately, the clear warm Pacific waters that surround the Islands also account for a significant number of injuries and illnesses.

Illustrative of the aquatic-related medical problems that afflict Hawaii's residents and visitors is the occurrence of dysbaric diving accidents. This state has the highest incidence of decompression sickness or "the bends" of any state in the United States. This malady was not unknown in the Islands before the introduction of SCUBA diving in the early 1950s; however, its frequency has greatly increased since then, especially in the last few years. This probably parallels the increasing numbers of people who have taken to the submarine environment for work and play.

The record number of diving accidents treated in 1979 culminated a busy decade for the bends business in Hawaii. Yet, it is well known that the cases which are actually treated represent only a portion of the total number of cases that occur. This may be why dysbaric osteonecrosis or "diver's bone rot" is so frequent among Hawaii's diving fishermen.

In addition to bends and air embolism cases, several drownings and near-drownings occur each year among snorkelers and scuba divers, as well as many more such cases among swimmers, surfers, waders, and boaters, not to mention bathtub and fish-pond cases.

When it is not drownings or bends, there are numerous accidents from surfing, body-surfing, and wind-surfing. Indeed, nowhere else in the world has so many surfers doing so many types of surfing in such a small area.

Similarly, consider the medical problems related to power-boating and water-skiing, deep-sea and shore fishing, sailing, canoe-paddling, and ski-dooing, all of which are vigorously pursued by certain segments of the community.

Still another aspect of aquatic medicine that is replete with local case material is marine toxicology. Cases of ciguatera and other fish poisonings, Portuguese Man-of-War envenomations, sea-urchin injuries, lion-fish stings, algae and sponge dermatitides, and aquatic infectious diseases all occur with some regularity among Hawaii's beachgoers and aquanauts.

Furthermore, as the main referral center for the Trust Territory of the Pacific Islands and the Central Pacific basin, Honolulu receives a number of unusual marine-related medical problems from other areas too.

Thus, it is not surprising that Hawaii's health care practitioners see a multitude of water-related medical problems, probably more than anywhere else in the United States. What is surprising is the relatively meager attention that is focused on aquatic medicine per se. The combination of a unique geographical and environmental setting and a sizable population with its concomitant resources provides Hawaii with the opportunity to become a leader in the field of aquatic medicine. Viewed in another way, we have a natural resource that could be developed to a far greater degree than it has been so far.

One effort along these lines was the establishment of the Hawaii Undersea Medical Association, Inc. (HUMA), in 1979. HUMA was organized to provide a forum for communicating information related to undersea and hyperbaric medicine, to provide a vehicle for education in these areas, and to promote diving and water safety.

The need for such an organization was underscored recently when the Navy announced that it could no longer provide primary treatment responsibility for all diving accidents. As a result of that decision, the State of Hawaii now has the opportunity to create a truly excellent hyperbaric treatment and research facility. The large number of diving accidents that occur here and the expertise present at the University of Hawaii and elsewhere in the Islands provide the basis for establishing an undersea and hyperbaric medicine facility that would be unexcelled anywhere. This facility might also provide a nidus around which interest and research in other areas of aquatic medicine may grow. It is hoped that the Legislature and administration will provide the backing that will make this a reality.

Accepted for publication February 1980.



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Screening for Tay-Sachs Carriers in Hawaii, 1980

Y. Edward Hisa, M.D.* *and* Jordan Popper, M.D.

Tay-Sachs disease is a degenerative neurolipidosis, affecting 1 in 3,500 young children when both parents are of Northern European Jewish (Askhenazi) ancestry, contrasted to 1 in 250,000 among other populations. This incurable disease is due to inherited deficiency of the lysosomal enzyme hexoseaminidase A (Hex A). Enzyme levels in parents of an affected child are consistently lower than normal.

Testing for this enzyme in Jewish communities throughout North America, Europe and the Middle East has confirmed that 1 out of 30 Ashkenzim are Tay-Sachs carriers with decreased Hex A activity, compared with 1 out of 300 among other ethnic groups. Normal test results gave full assurance to an individual that no children would be at risk for Tay-Sachs disease.

Abnormal results, when husband and wife were both carriers, predicted a 25% risk that a child will have this tragic condition. Such knowledge enables a couple to be forewarned, and to elect amniocentesis for measuring Hex A in cells from the fetus. By this means, birth of affected infants have been averted.

In 1980, leaders of the Jewish community in Honolulu and the Medical Genetic Services, using donated facilities and support from Tripler Army Medical Center, offered Hex A testing to all concerned individuals, particularly from the local Jewish community.

Following public explanations in newspapers, radio, television and at open meetings, 2 open screening sessions were held in June, 1980. Blood specimens from participants were processed at the Tripler Blood Bank and sent to the California Tay-Sachs Disease Prevention Program at UCLA-Harbor Medical Center for this sophisticated enzyme test.

The 70 participants included 4 with current pregnancies and 9 participants with known carrier relatives. All of the participants were found to be non-carriers, including 2 with indeterminant results requiring additional testing and 3 pregnant women requiring leucocyte Hex A assays.

In Hawaii, less than one affected child would be predicted per decade. The aim of this project, therefore, was to inform individuals about their Hex A status, rather than to detect and prevent the birth of affected children. It also aimed to provide health education, and offered an opportunity for many volunteers to contribute to a community health project. (The emotional, human and economic costs of even one affected child has amply justified the investment in screening 1,000 prospective parents to find one couple at risk.)

For each individual participant, negative reassuring information was obtained at a cost of $10. To test individuals separately would require either travel to California or shipment of frozen specimens at almost 10 times the cost. All participants, and the 30 children of couples who were both tested (see table), have learned reassuring, potentially important, information at a cost less than an evening's entertainment.

The program would have been more successful if many more people had participated, but the proportion of participants is comparable to that in similar projects elsewhere. Not everyone can cope with this type of information. Furthermore, an unknown proportion of the local Jewish population may already have been tested elsewhere. It may be many years before increased public demand will justify repeating a Tay-Sachs project locally.

* Professor of Genetics and Pediatrics
Director of Medical Genetic Services, John A. Burns School of Medicine, University of Hawaii

Accepted for publication October 1980.

REFERENCE

MM Kaback: Tay-Sachs Disease, Screening and Prevention. AR Liss, New York, 1977.

Participants in Hawaii Tay-Sachs Screening Project, 1980

FAMILY STRUCTURE OF PARTICIPANTS	FAMILY PLANS: MORE CHILDREN	NO MORE CHILDREN	UNDEDICED	NUMBERS TESTED
Couples With Children	11	2	3	32
Couples Without Children	—	2	1	6
Fathers (Tested Alone)	3	1	2	6
Mothers (Tested Alone)	2	—	1	3
Single Men	—	—	16	16
Single Women	—	—	7	7
				70

AGE:	UNDER 20	20-29	30-39	40-49	50-59	OVER 60	TOTAL
NUMBER:	4	20	25	7	8	6	70

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Red Blood Count and Hemoglobin Level in Healthy Student Nurses of Oriental Extraction in Hawaii

Robert T.S. Jim, M.D., Honolulu

Among some physicians in Hawaii there has been an impression that the hemoglobin level among Orientals is lower than that for Caucasians. As one test of this hypothesis, a study of red blood cell count and hemoglobin level of normal Oriental student nurses was carried out and compared with a similar study in healthy adult Caucasian women conducted in Spokane, Washington.[1]

Materials and Methods

The health records of 679 female student nurses from the University of Hawaii and Queen's Hospital schools of nursing were examined for red blood cell count and hemoglobin level. A total of 654 were of Oriental and 25 of Caucasian extraction. Of the 654 Oriental students, 557 were Japanese, 54 Chinese, 22 Koreans, 15 Filipinos, 2 Filipino-Japanese, 2 Chinese-Korean, 1 Korean-Japanese, and 1 Chinese-Korean. The ages of these students ranged from 18 to 21. Health charts were examined, dating back to the 1930s. Most of the records examined covered the 1940-1960 period. Photometric measurement of oxyhemoglobin was used for hemoglobin determinations. After 1960, hemoglobin determination by the cyanmethemoglobin method was employed for the Queen's Hospital School of Nursing students. Red blood counts were done by the usual chamber method.

Results

The overall average red blood cell count and hemoglobin level for the 654 Oriental student nurses were 4.52 million and 12.5 grams, respectively. The red blood count ranged from 3.64 to 5.59 million, while the hemoglobin ranged from 10.3 to 15.4 grams. Breakdown of the 654 Oriental student nurses by various ethnic groups revealed

TABLE 1

Ethnic Group	Red Blood Count (Million) Range	Average	Hemoglobin-Grams Range	Average
Japanese	3.64-5.59	4.53	10.6-15.4	12.6
Chinese	3.65-5.36	4.53	10.3-14.5	12.4
Korean	4.02-5.25	4.48	11.2-14.2	12.5
Filipino	4.10-5.10	4.53	11.0-14.5	12.3
Caucasian	4.05-5.00	4.48	10.9-13.0	12.4

no significant differences in the red blood count and hemoglobin level among any groups (see Table 1). The average red blood count and hemoglobin level for the 25 Caucasian students were 4.48 million and 12.4 grams, respectively, with the red blood count ranging from 4.05 to 5.00 million, and hemoglobin ranging from 10.9 to 13.0 grams (see Table 1).

Accepted for publication May 1980.

Discussion

The overall average red blood count of 4.52 million cells and hemoglobin of 12.5 grams for Oriental student nurses found in this study do not appear to be significantly different from the average red blood count and hemoglobin found in a survey of 623 normal adult female Caucasians, ranging in ages from 11 to 69, in Spokane, Washington. In the Spokane study, the overall average hemoglobin determination was 12.5 grams, with 95 percent of the women falling in the 10.2 gram to 14.8 gram range. In the 11 to 29 age group, the average hemoglobin was 12.6, and average red blood count 4.38 million. The average red blood count was 4.37 million with a range of 3.81 million to 5.03 million. Although the Hawaii study was small, the red blood count and hemoglobin, at least in healthy Oriental student female nurses in the age 18 to 21 range, did not appear to be lower than their Caucasian counterparts.

In another study of blood counts for normal children 3, 4 and 5 years of age, living in Hawaii, by Hamre and Wong in 1940, no significant differences were found for the red blood count and hemoglobin level between Caucasians and Chinese, Japanese, or Koreans.[2]

As thalassemia and certain abnormal hemoglobinopathies are prevalent among certain Oriental groups in Hawaii, information concerning the normal red blood count and hemoglobin levels for Orientals is of considerable importance in the diagnosis of these diseases.

Summary

In a study of the health records of 654 Oriental female student nurses ranging in ages from 18 to 21, the average red blood count and hemoglobin found was to be 4.52 million and 12.5 grams, respectively. The average red blood count and hemoglobin for a comparable group of 25 Caucasian female student nurses was 4.48 million and 12.4 grams, respectively. Breakdown of the Oriental student nurses by major ethnic groups, i.e., Japanese, Chinese, Filipino, and Korean, revealed no significant differences in the red blood count and hemoglobin levels among these groups. The red blood count and hemoglobin levels for healthy student nurses of Oriental extraction in the age 18 to 21 range appear to be almost identical to the red blood count and hemoglobin levels in normal adult Caucasian women of a comparable age group in Spokane, Washington.

REFERENCES

1. Judy HD and Price NB: Hemoglobin Level and Red Blood Count Findings in Normal Women. JAMA 167:563, 1958.
2. Hamre CJ and Wong KKL: Hematologic Values for Normal Children, Three, Four and Five Years of Age Living in Hawaii. Am. J. Dis. Child. 60:22, 1940.

INSTRUCTIONS TO AUTHORS HAWAII MEDICAL JOURNAL

SUMMARY OF REQUIREMENTS

Type manuscript double spaced, including title page, abstract, text, acknowledgments, references, tables, and legends.

Each manuscript component should begin on a new page, in this sequence:

Title
Text
Acknowledgments
References
Tables: each table, complete with title and footnotes, on a separate page
Legends for illustrations

Illustrations must be good quality, unmounted glossy prints usually 12.7 by 17.3 cm. (5 by 7 in.) but no larger than 20.3 by 25.4 cm. (8 by 10 in.).

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Manuscripts will be reviewed for possible publication with the understanding that they are being submitted to one journal at a time and have not been published, simultaneously submitted, or already accepted for publication elsewhere. This does not preclude consideration of a manuscript that has been rejected by another journal or of a complete report that follows publication of preliminary findings elsewhere, usually in the form of an abstract. Copies of any possibly duplicative published material should be submitted with the manuscript that is being sent for consideration.

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TEXT: The text of observational and experimental articles is usually—but not necessarily—divided into sections with the headings: Introduction, Methods, Results, and Discussion. Long articles may need subheadings within some sections to clarify their content, especially the Results and Discussion sections.

Introduction: Clearly state the purpose of the article. Summarize the rationale for the study or observation. Give only strictly pertinent references, and do not review the subject extensively.

Methods: Describe your selection of the observational or experimental subjects (patients or experimental animals, including controls) clearly. Identify the methods, apparatus (manufacturer's name and address in parenthesis), and procedures in sufficient detail to allow other workers to reproduce the results. Give references to established methods, including statistical methods; provide references and brief descriptions of methods that have been published but are not well known; describe new or substantially modified methods, give reasons for using them, and evaluate their limitations.

Include numbers of observations and the statistical significance of the findings when appropriate. Detailed statistical analyses, mathematical derivations, and the like may sometimes be suitably presented in the form of one or more appendixes.

Results: Present your results in logical sequence in the text, tables, and illustrations. Do not repeat in the text all the data in the tables and/or illustrations: emphasize or summarize only important observations.

Discussion: Emphasize the new and important aspects of the study and conclusions that follow from them. Do not repeat in detail data given in the Results section. Include in the Discussion the implications of the findings and their limitations and relate the observations to other relevant studies. Link the conclusions with the goals of the study but avoid unqualified statements and conclusions not completely supported by your data. Avoid claiming priority and alluding to work that has not been completed. State new hypotheses when warranted, but clearly label them as such. Recommendations, when appropriate, may be included.

ACKNOWLEDGMENTS: Acknowledge only persons who have made substantive contributions to the study. Authors are responsible for obtaining written permission from everyone acknowledged by name because readers may infer their endorsement of the data and conclusions.

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Use the form of references adopted by the U. S. National Library of Medicine and used in *Index Medicus*. The titles of journals should be abbreviated according to the style used in *Index Medicus*.

TABLES: Type each table on a separate sheet; remember to double space. Number tables consecutively and supply a brief title for each. Give each column a short or abbreviated heading. Place explanatory matter in footnotes, not in the heading. Explain in footnotes all nonstandard abbreviations that are used in each table. For footnotes, use the following symbols in this sequence: *, †, ‡, §, ‖, ¶, **, ††. . . . Identify statistical measures of variations such as SD and SEM.

ILLUSTRATIONS: Submit the required number of complete sets of figures. Figures should be professionally drawn and photographed; freehand or typewritten lettering is unacceptable. Instead of original drawings, roentgenograms, and other material, send sharp, glossy black-and-white photographic prints, usually 12.7 by 17.3 cm. (5 by 7 in.) but no larger than 20.3 by 25.4 cm. (8 by 10 in.). Letters, numbers, and symbols should be clear and even throughout, and of sufficient size that when reduced for publication each item will still be legible. Titles and detailed explanations belong in the legends for illustrations, not on the illustrations themselves.

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Hawaii Academy of Family Physicians' Newsletter

DON AND MARLIES FARRELL

U.H. medical students show continued interest in family practice, and we welcome **Constance Williams**, a fourth-year student as our new member this month.

Since the U.H.-Kaiser family practice residency program was phased out, **Don Farrell** has stepped down as chairman of the department of Family Practice and Community Health; **Dean Rogers** has appointed **Dr. Robert Worth** to fill that position.

Mahalo to **John** and **Deanna Aoki** who graciously hosted our last dinner meeting at their Kailua home. **Allen Richardson**'s talk on "Arthroscopy" was timely, with football injuries making the news again; and **John Corboy** proved a persuasive advocate for the Physicians' Union.

The November 7 dinner meeting at the home of **Don and Marlies Farrell** in Kaneohe will feature **Dr. Lee Jacobs**, chief of the Department of Medicine at Kaiser Medical Center, speaking on "Infectious Disease in Family Practice." The non-medical portion of the program may be of more than usual interest to spouses, with **Pat and Patty Westerhouse**, a husband-wife management consultant team, presenting "Self Worth, the Key to Effective Communications."

At the AAFP Congress of Delegates in Las Vegas, a resolution "To Urge All Governments to Abolish Nuclear Weapons," sponsored by the Hawaii chapter, was introduced by delegate **Tom Cahill.** Delegate **Don Farrell** was appointed chairman of the Reference Committee on Public Policy, which considered Hawaii's resolution among others. In next month's newsletter we will feature a report by our delegates on actions of this year's Congress.

You may already have received your notification of the HAFP annual meeting and seminar. We urge you to register early. A tear-off sheet has been provided in the brochure for your convenience. Council President **James Tsuji** has named **Pat Dietrich** as chairman of the Nominating Committee. She would like to receive your nominations for council members and officers. Please call her at 533-6112.

A few CME notes: Send your yellow cards to Kansas City right away if you have not already done so. Computer printouts of all your reported CME hours are being readied now. This is especially important for those active members due for re-election at the end of this year.

The Georgia AFP Educational Foundation is offering another "Primary Care Update" home study program for winter 1981-82. In this program, 125 CME hours are available. For further information call **Marlies Farrell** at 235-3115.

Book Reviews



Controversies in Clinical Care. *By Victor M. Rosenoer, M.D., and Marcus Rothschild, M.D. (eds). New York, SP Medical & Scientific Books, 1981. 227 pp. index. $30.*

Twenty-one contributors, plus the editors, have produced these 12 essays on a variety of controversial clinical issues in medicine, comprising such topics as lithium therapy, alcoholism, asymptomatic gallstone disease, corticosteroid therapy of hepatitis, borderline hypertension, TIAs, blood sugar control in diabetes, adjuvant therapy for breast cancer, fasting metabolism, and albumin therapy. In almost all, the pertinent literature is reviewed in depth and detail; references are copious and many run through the late seventies.

It's not light reading; the print is small; however, the editing is competent and the essays are well written and extremely informative. It is recommended.

Harry L. Arnold Jr., M.D.

Mesmerism. *By F.A. Mesmer; translated by George J. Bloch. Los Altos, Calif., William Kaufman, 180 pp. index, glossaries, appendices. Hardcover $11.50.*

Franz Anton Mesmer's writings on *Le Magnetisme Animal* have never before been collected in one volume. Born in 1734, he was made a doctor of medicine by the University of Vienna in 1766, and entered medical practice in Vienna.

His cure of a few hysterical or neurotic patients gave him the idea that he had transferred "animal magnetism" from himself to them. Though he behaved for the most part like, and regarded himself as, an empirical scientist, he was in trouble almost from the start with the Church and with orthodox medical practitioners, and moved his practice to Paris after only 10 years, in 1777. Beginning with planetary influences, he moved soon to the use of actual magnets, then to "animal magnetism," and finally to something very like hypnosis. He ended by hoping that he had at least helped physicians to avoid unnecessary use of drugs and bloodletting, and that others might be able to advance his theories and his methods further than he had been able to.

In the field of psychotherapy, he was the first of the moderns, far ahead of his time, and his account of his theories and practices makes for fascinating reading.

Harry L. Arnold Jr., M.D.

The Complete Guide to Cosmetic Facial Surgery. *By John A. McCurdy Jr., M.D., FACS. Frederick Fell, New York, 1981. 278 pp. index. $12.95.*

Dr. McCurdy, from Maui, has written this book for the layman (or laywoman), and it contains information about the head and face cosmetic surgical procedures that are currently being done. The operations and their discussions are well indexed. There is an accurate description of the procedures, as well as of patient selection, realistic goals, and complications.

The chapter on selection of a physician for facial cosmetic surgery is a little confusing. It leaves the impression that plastic surgeons, otolaryngologists, ophthalmologists, dermatologists, and oral surgeons all do the same work. Dr. McCurdy identifies himself only as a member of the American College of Surgeons and as a facial cosmetic surgeon. He does not say in what specialty or specialties he has board certification.

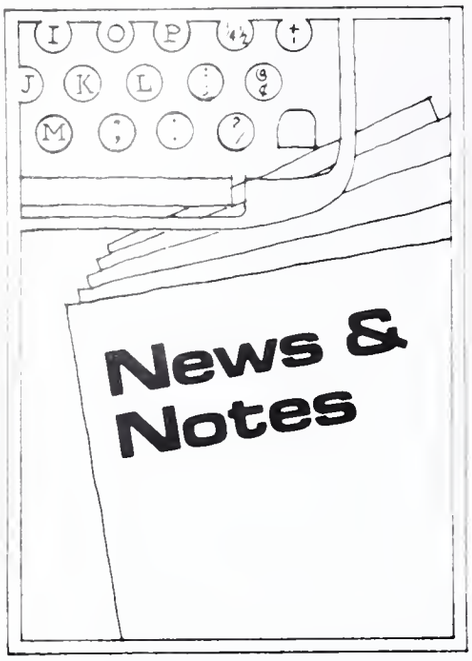
Although the Herculean task of writing a "complete" book is a difficult one, he has done a good job on this guide for the lay public on the common head and face cosmetic procedures.

James H. Penoff, M.D.

Emergency Psychiatry for the House Officer. *By William R. Dubin, M.D., and Robert Stolberg, M.D. New York, SP Medical Books, 1981. 107 pp. plus 54 pp. table of psychiatric side effects of drugs; index. Paperback, $15.*

Emergency Psychiatry for the House Officer is a valuable guide to the common emergency room psychiatric problems. First, the psychiatric exam is clearly presented in simple outline form. Then, a concise and pertinent review of a problem is given, with an outlined approach, which includes lab studies, appropriate goals and disposition. Many useful patient management techniques and suggestions are also offered. In addition, there is a useful 54-page index to medical drugs with psychiatric side effects.

Mark Chung, M.D.



HENRY N YOKOYAMA, M.D.

Conference Notes . . .

Lee Jacobs, chief of medicine, Kaiser Hospital, gave an excellent talk on UTIs at a July QMC Friday morning conference . . . Herein are excerpts from his handout:

Urinary Tract Infections

I. Defined:
A. Microbial invasion of any tissue of the urinary tract extending from the urethral meatus to the renal cortex.
B. Significance of 10^5 organisms:
1. On one clean catch urine — 80% specific (95% on 2 urines)
2. Fewer (10^3 or less) organisms can signal true infection when:
a. Rapid urine flow
b. Presence of antibiotic or antiseptic
c. Low urine pH
d. Partial or complete obstruction
e. Catheter specimen
f. A.U.S. (Acute urethral syndrome)
C. Significance of Pyuria:
10 WBCs/hpf = 40% 10^5 growth
20 WBCs/hpf = 83% 10^5 growth
D. Finding of organisms or gram stain of fresh, unspun urine is highly suggestive of UTI.
E. Numerous squamous epithelial cells strongly suggests contamination.

II. Types of UTIs:
Asymptomatic bacteruria
Acute urethral syndrome
Cystitis
Pyelonephritis
Prostatitis
Perirenal abscess
Renal carbuncle

III. Prevalence:
A. Age Group/Prevalence (%) — Approx. Sex Ratio (Male: Female)

Neonatal - 1	1.5:1
Preschool age - 1.5-3	1:10
School age - 1.2	1:30
Reproductive age - 2.5	1:50
Geriatric - 10-30	1:1

B. 10-20% of females will have UTI during lifetime
C. Adult women — incidence increases with age + sex
D. Diabetic —
Increased "silent" renal infection
Increased susceptibility when disabled or catheterized

IV. Pathogenesis:
A. In two major routes —
Hematogenous (less than 5%)
Urethral (greater than 95%)
B. Mechanism:
1. Colonization of vaginal vestibule with g.n. rods from stool
a. Role of Adherence:
Adherence markedly increased in recurrent UTI patients and decreased in same patients with antibiotic prophylaxis
Adhesion to mucosal surface a pre-requisite for invasion of host by a pathogen.
b. Host defenses to prevent vaginal/urethral colonization:
1. Mechanical: ciliary action; mucous blanket; urine flow
2. Immunological:
IgA antibodies against organisms in cervicovaginal secretion.
2. Colonization/Infection of the bladder:
a. Most virulent organisms overcome defense mechanisms by attacking rapidly
b. Defense mechanisms to prevent bladder colonization: mechanical; immunological; urine bacteriostatic when low pH
c. Voluntary retention encourages recurrent UTIs.
d. Usually superficial mucosa (unless foley, anatomic defect, etc)
e. If damages superficial, head vessel — "hemorrhagic cystitis"
3. From bladder to kidney:
a. 30-50% of cystitis in women extend to kidney
b. Normally a valve-like ureterovesical junction prevents urine reflux
Reflux found in cystitis, pregnancy, obstruction
c. Cystitis predisposed to pyelonephritis: impaired bladder function; V-U reflux; urethral obstruction; diabetic; foreign material; nephrotoxic strains

V. Bacteriology:
1. Species:
a. Previous infection . . .
Resistant: Non E. coli
b. Hospitalization . . .
Resistant: Non E. coli
c. Instrumentation . . . Staph aureus, Enterococcus, Pseudomonas
d. Underlying Disease . . .
Candida, Cryptococcus
e. Contamination . . . Diptheroids, Staph, Lactobacillus
2. E. Coli makes up 90% outpatient isolate/50% inpatient
3. Role of "Staph-coag-negative" — Staph saprophyticus
a. 10% of UTIs; 20% in young females
b. Versus staph. epidermitis:

	Staph epidermitis/Staph saprophyticus
Contaminant:	common / rare
Indigenous flora:	common / rare
Pathogenic-UTI:	rare / common
uroepithelial adherence:	poor / marked

VI. Clinical Features
A. Acute urethral syndrome (A.U.S.) — "Symptomatic abacteruria"
1. Can't separate cystitis vs A.U.S. clinically:
2. Women (24-60 y/o):
20% have dysuria/yr
1/2 seek medical attention
2/3 have true UTI
2/3 have A.U.S.
3. Defined:
No 10^5 organism
No V.D. organism
No vaginitis
70% have pyuria — 9/10 of these are treatable infections
4. Infectious agents: coliforms, S. saprophyticus, chlamydia, herpes
5. Antibiotics:
Sulfa/TCN may be helpful if pyuria
Criteria of greater than 10^5 is insensitive
Chlamydia common
B. Upper tract vs lower tract
1. Manifestations:
Symptoms of lower urinary tract infection: frequency, burning, suprapubic pain
Symptoms of upper tract infection: loin pain, fever, rigors, nausea and vomiting, macroscopic hematuria
2. Techniques:
Direct: bladder washout; ureter catherization
Indirect: urinary concentration, urinary enzymes, antibody coating, bacteria assay
C. Prostatitis:
a. Pathogenesis poorly understood
b. Acute — responds to conventional antibodies
c. Chronic — Bactrim best
d. Relapse frequent — choice:
1. Surgery
2. Retreat each relapse
3. Long term suppression
D. Asymptomatic bacteruria
1. Pregnant female:
Bacteruria is 4-10% (double nonpregnant women)
If asymptomatic bacteruria is not treated, 25% develop pyelo
2. Elderly:
Suggestion of decreased survival . . . 30%-50%
Should all be treated? controversial . . .
Treat all males; treat females once . . .
E. Recurrent UTIs
1. Relapse — Recurs in days; same organism; reappears from sequestered foci after antibiotics
2. Reinfection — reinfection in weeks/months; treatment successfully eradicated infection; organism re-introduced from fecal reservoir; 80% of recurrent UTIs are due to reinfection
3. Natural History: Studies of adult women; attack rate 0.15 infection/month; 94% have symptoms with recurrent UTIs; 21% had less 10^5 organisms; 34% followed with 6 month infection free period; conclusion; culture only when symptoms; culture before treatment
4. Morbidity: recurrent infection in absence of anatomical abnormality does not lead to chronic renal failure
5. Prophylaxis: Trial of antibiotic prophylaxis indicated with low dose antibiotics when about 3 episodes/yr

Drugs:

TMP-SMX (40mg/200mg)	0.15
TMP (100mg)	0.10
Nitrofurantoin (100mg)	0.14

6. Conclusion: Infections more likely to reoccur after prophylaxis is discontinued in females with more than 3 infections per year before prophylaxis
 Low dose antibiotics — q.h.s.
 If positive A.C.B., the re-infection is more likely the same organism
 Rare antibiotic resistance develops, but more non-E. coli after prophylaxis

VII. Radiographic workup
1. Acute pyelo — slow resolution
2. Children less than 10 y/o . . . ? if female
3. All men with first UTI . . . ? if prostatitis
4. Recurrent UTIs despite adequate treatment . . . debatable

VIII. Treatment:
1. General: Conventional treatment 10-14 days tid or qid
 Clearly need different approaches for different sites.
2. Acute urethral syndrome
3. Cystitis — Acute and Uncomplicated
 a. Conventional treatment — 85% initial success
 b. 15% failure secondary to renal or prostate foci
 c. Single dose: Single dose therapy has not been proven efficacious for the general outpatient population
 d. Conventional Therapies:
 Gantrisin O. 5 gm qid for 10 days
 Gantanol 1.0 gm q 8 hr for 10 days
 Trimethroprim 100 mg bid for 10 days
 Nitrofurantoin 50 mg qid for 10 days
 Ampicillin 250 mg qid for 10 days
 Amoxicillin 250 mg tid for 10 days
 Keflex 250 mg qid for 10 days
4. Pyelonephritis: The exact duration of therapy is unknown
 If hospitalized: Initially aminoglycoside unless sensitivities known
 IV antibiotics for 3-5 days and until afebrile for 48 hrs
 Outpatient: 2-3 weeks of therapy
 For relapses: 6 weeks therapy

Miscellany . . .

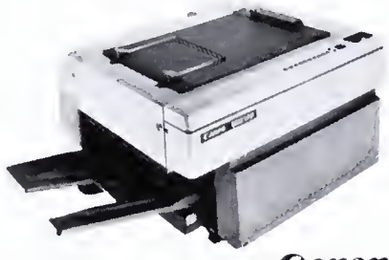
The golf nut was curious . . . He asked his priest to find out if there were golf courses in Heaven . . . The priest prayed at length and finally had a revelation . . . He summoned the golfer . . . "I have good news and bad news," intoned the priest . . . The anxious golfer asked, "Well, tell me the good news first . . . " "The good news is that there are dozens of excellent golf courses in Heaven . . . And you can play all you want . . . " "That's great . . . Then what's the bad news, Father?" "The bad news is that you have a 8:10 starting time for next Saturday . . . " (Walter Loo, our Realtor friend . . .)

The commuter was waiting for his bus, when he suddenly remembered . . . He rushed into the nearby hardware store and harried the clerk, "Hurry! Let me have a mouse trap . . . I'm catching the bus." The clerk repied, "Sorry, sir . . . But we don't carry a mouse trap that big." (Prof Sumiyama from Toho University . . .)

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HMA Auxiliary

1981 Auxiliary Leadership Conference

Confident of no danger associated with the air traffic controllers' strike, **Carol McNamee**, president-elect of the HMA Auxiliary; **Ella Edwards**, president-elect of the Auxiliary to the Honolulu County Medical Society; and **Kathy Oldfather**, secretary of the Hawaii County Medical Society (Hilo), traveled to Chicago in October.

As Hawaii's delegates to the 1981 Leadership Confluence, sponsored by the AMA Auxiliary, Carol, Ella, and Kathy were able, with delegates from other states, to participate in leadership and topic seminars designed to encourage community projects. Among the topics were, "Help! I'm the Parent of a Teenager"; "Life Stress Management Without Substances"; and, "The Family of the Impaired Physician."

Well-known organizational and community consultant, **Eva Schindler-Rainman**, spoke to the delegates on "Volunteerism in Transition."

The program for the Leadership Confluence aimed to present the Auxiliary's delegates with relevant information and necessary skills for leadership roles on the local level.

Annual Banquet

HMA's annual banquet, installation of officers, and 125th birthday party were all rolled into one festive affair at the Ilikai Hotel October 16. Auxiliary members donated time and talent to create an exciting carnival atmosphere. The Ilikai's Pacific Ballroom was resplendent with tent-like ceiling streamers (**Angie Navin** and **Dr. Ed Kagihara**); balloon bouquet table centerpieces (**May Kim**); skill and souvenir booths (**Dr. Philip McNamee, Carol McNamee**, and **Liz Lewis**); and rousing entertainment (**Dr. Ed Kagihara** and **Dr. Philip McNamee**). **Dr. Robert Flowers** designed the invitations and the overall coordinators were out-going HMA President **Neal Winn** and his wife, **Lynne.** Many other Auxiliary members helped with decorating the Ilikai on Friday and Saturday.

The Auxiliary thanks Dr. Winn for his productive year as HMA president and welcomes his successor, **Dr. Ann Catts.**

Introducing

Margie Cho Sue, Ph.D., R.D., new to the Honolulu Auxiliary board this year and a Hawaii resident for only a year, has already become well established in the community and her talents are being recognized. Margie is assistant professor at the University of Hawaii School of Public Health, Nutrition and Maternal Child Health Programs. She also writes a column every other week for the Honolulu Advertiser titled "Nutritionally speaking," a question-and-answer column answering readers' inquiries. She will serve the Auxiliary this year as publicity and newsletter chairman. **Dr. Sam Sue** is affiliated with the Straub Clinic and Hospital.

Because snacking is often the downfall of our good intentions to eat a balanced diet and keep those extra calories down, we asked Margie to share a few formulas for nutritious snacks that we could publish in this column when space is available.

Try this for a quick breakfast, lunch, or between, meal pick-up:

Fruit Shake

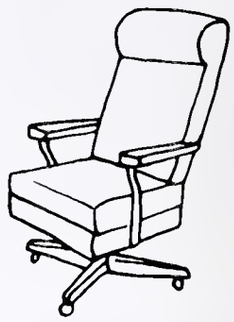
2 frozen bananas (med. size or larger)
2 cups skim milk
Approximately 1 cut fresh or frozen fruit (Papaya, mango, peeled apple cubes, strawberries, etc.)
1 tsp. vanilla extract

Place all ingredients in a blender and blend until smooth. Makes 3-4 serving. Fresh bananas can be used. However, frozen bananas contribute iciness and a thicker consistency. Freezing a bunch of bananas assures you will always be able to make this quick drink with any other fruit in the house! (Note: Freeze peeled bananas!)

Editor's Note: News, short articles about people and events, and suggestions about what you would like to see in this column are most welcome. Deadlines are 6 weeks in advance of puhlication of the JOURNAL, so plan to have them in by the 12th of the month for the issue to he puhlished 2 months later (e.g. articles submitted in November will be published in January).

Send your news to:
HMA Auxiliary
320 Ward Ave.
Honolulu, Hawaii 96814
Attn: Dorothy Shepard,
JOURNAL Auxiliary Ed.

Mahalo to Carol McNamee and Margie Sue for their contributions to this month's column.



Clinical Pathologist's Easy Chair

FRANCIS FUKUNAGA, M.D.

Hormone Receptors and Breast Cancer

The role of cytoplasmic hormone receptor assays in determining treatment strategies for breast cancer is well established. Estrogen receptor positive patients have about a 60% chance of responding to ablative or additive endocrine therapy, while receptor-negative patients are poor risks for endocrine manipulation. Receptor positivity and content of the tumor is highest in the postmenopausal patient (61%), intermediate in the premenopausal patient (29%), and lowest in the paramenopausal patients (11%).[1] There is no correlation between tumor histopathology and presence of receptors, nor correlation between the biologic aggressiveness of the tumor and receptors. The receptor proteins are degraded by autolysis and necrotic areas are negative. Metastases are typically similar to the primary lesion but occasionally there is loss of the positivity. The incidence of estrogen receptor positivity is greater in men with breast cancer (approximately 80%), while the prevalence of male breast cancer is only about 1% of that in females.[2]

The estrogen receptor positivity and response to endocrine therapy is similar in Japanese and American women. Although receptor positivity is higher in postmenopausal American women, the Japanese have a better 5-year survival.[3] The response rate to treatment is about 80% when both estrogen and progesterone receptors are positive. The predictability of the response to hormonal therapy is 91% if only the progesterone receptor result is used, and only 70% if based only on the estrogen receptors. Progesterone receptors are often present in estrogen receptor positive tumors, but rarely in estrogen receptor negative lesions. The higher the estrogen receptor content, the greater the likelihood that there will be significant progesterone receptor levels.[4]

Current biochemical methods for receptor assays require homogenization

and separation of the soluble tumor cytoplasmic protein, radioactive-isotope-labeled estradiol and progesterone, and measurement of the receptors by either or both the sucrose gradient centrifugation or the dextran-coated charcoal assay. Five femtomoles per mg of protein or less is considered negative for estrogen receptors; a biologically meaningful positive is over 10 femtomoles. There is approximately 45% response to therapy with values of 5 to 100 femtomoles per mg, and over 80% with values over 100 femtomoles per mg. A femtomole is 10^{-15} mole (millimole is 10^{-3} and micromole is 10^{-6}).

Progesterone receptors are considered negative if less than 10 and positive when greater than 10 femtomoles per mg of protein.

The transport and storage requirements of the specimen are very important. Liquid nitrogen transport yielded more and higher estrogen receptor positivity than did the use of dry ice.[5] Biopsy specimens submitted for frozen section usually show higher receptor levels (1.6 to 6.5 times) than mastectomy specimens do, possibly due to devitalization during mastectomy and delays in obtaining the mastectomy specimen.[6]

REFERENCES

1. Kiang DT: Factors affecting estrogen receptors in breast cancer, Cancer 40:1571-1576, 1977.
2. Friedman MA: Estrogen receptors in male breast cancer, Cancer 47:134-137, 1981.
3. Nomura, Y et al.: Estrogen receptor and endocrine responsiveness in Japanese vs American breast cancer patients, Cancer Res 37:106-110, 1977.
4. McGuire WL et al.: Current status of estrogen and progesterone receptors in breast cancer, Cancer 39:2934-2947, 1977.
5. Muschenheim F et al.: Increased incidence of positive tests for estrogen binding in mammary carcinoma specimens transported in liquid nitrogen, Amer J Clin Path, 70:780-782, 1978.
6. Hasson J et al.: Comparison of estrogen receptor levels in breast cancer samples from mastectomy and frozen section specimens, Cancer 47:138-139, 1981.



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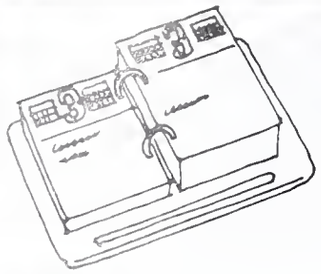
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Continuing Medical Education

CALENDAR OF ACCREDITED EVENTS—CATEGORY 1

(Accredited Programs of CME allow one unit of AMA credit for each hour of instruction excluding all "breaks")

LOCAL ACCREDITED PROGRAMS

ONGOING

American Cancer Society, Hawaii Division

1. Telephone Task Force w/G.N. Wilcox Memorial Hospital, First Thursday, 12:45 p.m. and Fourth Tues. 12:30 p.m. w/Maui Mem. Hsp. Held on Oahu at Am. Cancer Society main conf. room, 200 N. Vineyard, Honolulu.

John A. Burns School of Medicine

1. Dept. of Medicine
 - A. Case Conferences, Second and Fourth Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 - B. Grand Rounds, First and Third Tuesdays, 12:30-2:00 p.m., Queens University Tower, Room 618.
 - C. Endocrinology Grand Rounds, Second Thursday, 5:30-6:30 p.m., Queens University Tower, Room 506.
 - D. UH-Queens Conference, Fridays, 8:00-9:00 a.m., Queens Medical Center, Mabel Smythe Auditorium.
 - E. Cardiology Grand Rounds, First and Third Tuesdays, 5:30-6:30 p.m., Queens University Tower, Room 508.
 - F. Infectious Disease Grand Rounds, Second and Fourth Tuesdays, 5:00-6:00 p.m., Queens Nalani 1 Conference Room.
 - G. Dermatology Grand Rounds, Second Wednesday, 7:30-9:30 a.m., Queens Medical Center, Queen Emma Clinic.
 - H. Pulmonary Grand Rounds, Fourth Wednesday, 4:30-5:30 p.m., Queens Medical Center, Kamehameha Auditorium.
 - I. Nuclear Medicine Grand Rounds, Third Wednesday, 5:00-6:15 p.m., Straub Hospital, Doctors' Dining Room.
 - J. Medical-Surgical GI Grand Rounds, Third Friday, 12:45-1:45 p.m., Kuakini Hospital, PB4 Classroom.
2. Dept. of Obstetrics and Gynecology
 - A. Grand Rounds, Wednesdays, 7:30-8:30 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
3. Division of Orthopaedics
 - A. Fracture Conference, Mondays, 5:00-6:00 p.m., Queens University Tower, Room 618.
 - B. Shriners Hospital Conference, Tuesdays, 7:15-9:00 a.m., Shriners Hospital.
4. Dept. of Pediatrics
 - A. Grand Rounds, Thursdays, 8:00-9:00 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 - B. Pediatric Monday Noon Conference, Mondays, 12:45-1:45 p.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 - C. Pediatric Infectious Disease Conference, Thursdays, 12:30-1:30 p.m., Kapiolani-Children's Medical Center, Conference Room B.
 - D. Perinatal Grand Rounds, Fridays, 8:15-9:15 p.m., Kapiolani-Children's Medical Center, Conference Room B.
5. Dept. of Psychiatry
 - A. Grand Rounds, Fridays, 8:00-9:30 a.m., Queens University Tower, Room 618.
6. Dept. of Surgery
 - A. Grand Rounds, First, Second, and Third Saturdays, 7:30-9:00 a.m., rotating hospitals.
 - B. Statistical M and M, last Saturday, 7:30-9:00 a.m., rotating hospitals.
 - C. Journal Club, First and Third Tuesdays, 6:00-8:00 p.m., Queens University Tower, Room 620.
 - D. Medical-Surgical GI Rounds, Third Friday, 12:45-1:45 p.m., Kuakini Medical Center, PB4 Classroom.
 - E. Pediatric Surgical Grand Rounds, First Friday, 12:45-1:45 p.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
7. Dept. of Family Practice
 - A. Conference, Fourth Wednesday, 1:00-2:00 p.m., Kapiolani-Children's Medical Center, Second Floor Auditorium, Executive Dining Room.
8. Dept. of Family Practice
 - A. Conf., Wednesdays, 8:00-9:00 a.m., Kaiser 4th Floor Conf. Room.
 - B. Conf., Thursdays, 12:00-1:00 p.m., Kaiser 4th Floor Conf. Room.
9. Dept. of Physiology
 - A. Dept. Conf., Wednesday, 4:30-5:30 p.m., BioMed T-210.
10. University of Hawaii, John A. Burns School of Medicine Grand Rounds, Third Thursday, 4:30-6:00 p.m., Queen's University Tower, Room 618 or BioMed Building.
11. HI Oncology Group, one Monday a month, 12:30-1:30 p.m., The Cancer Center, 1236 Lauhala St., 4th Floor Conference Room.
11. HI Oncology Group, Usually Third Monday bimonthly, 12:30-1:30 p.m., The Cancer Center, 1236 Lauhala Street, Fourth Floor Conference Room.
 * Category II.

Federation of Emergency Medicine-Maui

1. **Cardiology for the Emergency Physician.** Every Monday, 9:00-10:00 a.m.-Maui Memorial Hsp. Conf. Rm #1. (For spec. topics or further info contact: Federation Office (808) 244-7629, or Dr. C.T. Mitchell, (808) 244-9056.
2. **Journal Club in Emerg. Medicine.** 2 hrs. Cat. 1. MMH Conf. Rm. #1. 9:00-11:00 a.m.
 11/23/81 Annals in Em Med, 7/81; Abstracts in EM 8/81 - J. Mills
 12/21/81 Annals in Em Med, 8/81; Abstracts in EM 9/81 - C. Mitchell

Hawaii Thoracic Society

1. Pulmonary Med., Clinical case presentations & current research in pul. med. with U of H Sinclair Chest Club, Third or Fourth Wednesdays, each month, 7:30 a.m.-9:30 p.m. For further info contact: Rosemary Respicio, B.S.N. at (808) 537-5966.

Hickam Clinic

1. Clinical Correlation Conference, First Thursday, 11:00 a.m.
2. Didactic—our staff, Second Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, Third Thursday, 11:00 a.m.
4. Radiology Conference, Fourth Thursday, 11:00 a.m. (Contact Aurora Macapinlac, M.D., M.C., 449-5770)

Hilo Hospital

1. Orthopedic Conference, First Tuesday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m., Saturdays, 7:00-8:00 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, Second Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, Third Friday, 12:30-1:30 p.m.
5. C.P.C., Second Friday, 12:30-1:30 p.m.
6. Visiting Professor's Program

Kaiser Hospital

1. Medicine Grand Rounds, Every Tuesday, 8:00 a.m. Pac. Aud. 1 hr. Cat. 1.
2. Tumor Board, Every Tuesday, 12:00 noon. Pac. Aud. 1 hr. Cat. 1.
3. OB/Ped. Perinatal Mortality Conference, Last Tuesday, each month. 8:00 a.m. 1 hr. Cat. 1.
4. Surg. Grand Rounds, Every Friday, 8:00 a.m. Pac. Aud. 1 hr. Cat. 1.
5. Saturday Morning Educational Conference, Every Saturday, 7:30 a.m. Pac. Aud. 1 hr. Cat. 1.

(Contact CME Dept.-Kaiser for further information)

Kapiolani-Children's Medical Center

1. Pediatric Grand Rounds, Every Thursday, 8:00-9:00 a.m., Aud.
2. Pediatric Conference, Mondays, 12:45-1:45 p.m., 2nd Floor Aud.
3. Neonatal Grand Rounds, Friday, 8:00-9:00 a.m., Conference Room B.
4. Pediatric Infectious Disease Conference, Thursdays, 12:30-1:30 p.m., 3rd Floor Conf. Rm.
5. Ob-Gyn Conference, Tuesday, 1:00-2:00 p.m., Aud.
 First—Didactic Presentation
 Second—Perinatal-Neonatal Topics
 Third—Obstetrics Topics
 Fourth—Gyn Topics
6. Tumor Board, Oncology Conference, First and Third Friday, 1:00-2:00 p.m., Aud.

Kuakini Medical Center

1. Department of Ophthalmology Mtg., First Tuesday, 12:30-1:30 p.m.
2. Department of Medieine Mtg. (Statistical), Fourth Tuesday, 1:00-2:00 p.m.
3. G.I. Conference, First Tuesday, 8:00-9:00 a.m.
4. Nephrology Conference, First Wednesday, 8:00-9:00 a.m.

5. Oncology Conference, Every Thursday, 7:30-8:30 a.m.
6. Pulmonary Conference, First Thursday, 1:00-2:00 p.m.
7. Surgical Conference, First & Second Friday, 12:45-1:45 p.m.
8. Surgical M&M Conference, Fourth Friday, 12:45-1:45 p.m.
9. Department of Medicine Evening Mtg., Second Tuesday, 5:30-7:00 p.m.
10. Visiting Professor Program (for further info contact CME Dept. 547-9226 as these programs may be subject to change.)

Maui Memorial Hospital

1. Thursday Conference, 7:00-8:00 a.m., Staff Dining Room.
 First—Dept. of Medicine
 Second—Dept. of Surgery
 Third—Dept. of OB/GYN
 Fourth—Dept. of Pediatrics
 Fifth—Elective
2. Tumor Board, Every Monday, 12:15-1:15 p.m.—Tumor Conference Telephone Task Force—Third Tuesday, 12:15-1:15 p.m.
3. Dept. of Emergency Medicine, Third Monday, 7:00-8:00 a.m.
4. Diagnostic Radiology, Fourth Tuesday, 12:00-1:00 p.m.
5. SFH-UH Hematology Conf., Third Thursday, 12:30 p.m., Sullivan-4 Classroom.
6. SFH-UH Surgical Grand Rounds, First, Second & Third Fridays, 7:30 a.m., Sullivan-4 Classroom.
7. Visiting Professor Programs (for further info call CME office at St. Francis).

Hawaii Ophthalmological Society

1. Monthly dinner meeting, Third Thursday of each month. Contact: Dr. A. Kunimoto, (808) 941-2208.

The Queen's Medical Center

1. ENT Conferences, First and Second Fridays, 7:30 a.m., Small Dining Room.
2. Medical Conferences, Every Friday, 8:00 a.m., Kam Auditorium.
3. Ob/Gyn Conferences, Second and Fourth Mondays, 1:00 p.m., Kam Auditorium.
4. Ophthalmology Conference, Fourth Tuesday, 5:00 p.m., Queen Emma Eye Clinic.
5. Orthopaedic Conferences, Every Wednesday, 7:00 a.m., Kam Auditorium.
6. Pathology Conferences, Every Wednesday, 7:30 a.m., Surgical Conference Room.
7. Pediatric Grand Rounds, Fourth Thursday, 12:30 p.m., Nalani I Conference Room.
8. Surgical Trauma Conference, Second Tuesday, 4:30 p.m., Kam Auditorium.
9. Basic Science Lectures, Every Wednesday, 7:15 a.m., Queen's University Tower, Room 618.

St. Francis Hospital

1. SFH-UH Tumor Conference, Every Monday, 7:30 a.m., Sullivan-4 Classroom.
2. SFH-UH Nephrology Conference, First Monday, 1:00 p.m., Sullivan-4 Classroom.
3. SFH-UH Endocrine Conference, Last Monday, 12:30 p.m., Sullivan-4 Classroom.
4. EENT Meeting, First Tuesday, 7:00 a.m., Sullivan-4 Classroom.
5. SFH-UH Hematology Conference, Third Thursday, 12:30 p.m., Sullivan-4 Classroom.
6. SFH-UH Surgical Grand Rounds, First, Second & Third Fridays, 7:30 a.m., Sullivan-4 Classroom.
7. Visiting Professor Programs (for further info call CME office at St. Francis).

Straub Clinic & Hospital

1. Straub Professional Seminar meets the Second Tuesday of each month from 5:00-6:30 p.m. in the Credit Union Meeting Room (2nd Floor, Credit Union Bldg.)
2. Surgical Mortality and Morbidity Conference meets every Fourth Thursday of each month, from 7:00-8:00 a.m. in the Doctors' Dining Room.
3. Cardiac Surgery Conference meets the Third Tuesday of each month from 4:30-5:30 p.m. in the Doctors' Dining Room.
4. Department of Anesthesiology meets the Second Tuesday of each month from 7:00-8:00 p.m. in the Doctors' Dining Room.
5. Community Peripheral Vascular Conference meets the Fourth Thursday of each month from 5:00-6:30 p.m. in the Doctors' Dining Room.
6. Visiting Professor Program meets monthly from 7:00-8:00 a.m. in the Doctors' Dining Room.
7. Urology Inservice meets every other month on the Third Friday from 8:00-9:00 a.m. in the Doctors' Dining Room.
8. Neuropathology Clinical Correlation Conference meets the Third Thursday of each month from 7:30-8:30 a.m. in the Straub Morgue.
9. OB-GYN Pathology meets every Fourth Monday of each month from 12:30-1:30 p.m. in the Administration Conference Room (ACR).
10. Urologic Pathology meets every First Monday of each month from 8:00-9:00 a.m. in the Doctors' Dining Room.
11. Friday Noon Conference meets Every Friday of each month from 12:30-1:30 p.m. in the Doctors' Dining Room.

*Note: All conferences are subject to change. Monthly calendar will be available upon request.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. General Medical Staff Meeting, Quarterly in January, April, July & October.
2. Clinical Review Meeting, Alternate Mondays at noon.
3. Tumor Conference, First Thursday.

Miscellaneous

HMA Maternal and Perinatal Mortality Study Committee, First Monday each month - 5:30 p.m. 320 Ward Ave., S 200.
Cat. 1 on hr. for hr. basis.

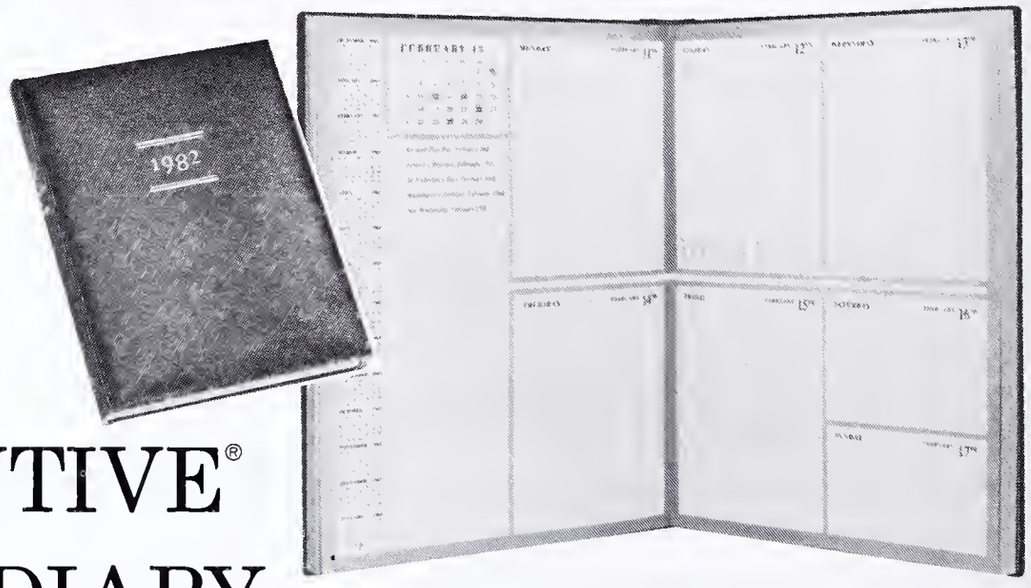
SPECIAL EVENTS

Nov. 5 1981	Ethno-Medicine: Crossing Cultures to Humanize Health Care, Ala Moana Hotel, Contact: Irene Kodani, Aux. to HCMS, 536-6988, 6 hrs.
Nov. 20-23, 1981	Adv. Electrocardiography Workshop, Tampa Tracings, Box 14405, St. Petersburg, FLA 33733, At: Kauai Surf, Kauai, 18 hrs.
Dec. 10-12, 1981	The Phys. Role in Quality Assurance & Risk Management, Div. of Quality Control Mgmt., 840 N. Lake Shore Dr., Chicago, Ill. 609064, At: Kahala Hilton Hotel. 10 hrs.
Jan. 6-23, 1982	Nephrology USC Sch. of med. Postgrad Med., 22025 Zonal Ave., LA 90033, at: Mauna Kea Beach Hotel, Kamuela, 30 hrs.
Jan. 8-15, 1982	Sixth Ann. Echocardigraphy in Hawaii, Hon Med Group Res. & Educ. Found, 550 S. Beretania St., Honolulu, Hawaii 96813, 30 hrs. At: Kauai Surf Resort.
Jan. 9-15, 1982	Gastrointestinal & Hepatic Disease, Hon. Med Group Res. & Educ. Found. 550 S. Beretania St., Honolulu, Hawaii 96813. 30 hrs.
Jan. 10-15, 1982	Sem on Gastro-Enterology, UH John A. Burnsh School of Medicine, 1960 East-West Road, Honolulu, Hawaii 96822 at: Hyat, Maui, 6 days.
Jan. 11-15, 1982	Perinatal Med., USC Sch. of Med. Post Grad. Div., 2025 Zonal Ave., LA 90033, At: Royal Lahaina Hotel Maui, 30 hrs.
Jan. 11-14, 1982	Congress of the Pan Pacific Surg. Assn. Box 553, Hon.,, 96809, At: Sheraton-Waikiki, 2255 Kalakaua Ave., Honolulu, Hawaii 96815, 30 hrs.
Jan. 18-20, 1982	Pediatric Emergencies, UH John A. Burns School of Medicine, 1960 East-West Rd., Hon., Hi 96822, At: Kapiolani-Childrens Med. Ctr., 1319 Punahou St., Honolulu, Hawaii 96826, 10 hrs.
Jan. 25-30, 1982	Controversies in Emergency Med., UC San Diego, Sch. of Med., Office of Cont. Education, M-017, La Jolla, Calif. 92093 At: Kona Surf 21 hrs.
Jan. 30-Feb. 6 1982	Acute Situations in Primary Care, UC San Diego Sch. of Med., Off. of Cont. Educ. M-017, La Jolla, CA 92093 At: Wailea Beach Resort, Maui, 21 hrs.
Jan. 30-Feb. 6 1982	Diagnostic Sems. UC San Francisco, Dept. of Radiology, Rm M-396 Third & Parnassus Ave., San Francisco, Calif. 94143. At: Maui Surf Hotel, Maui.
Feb. 4-5, 1982	35 hrs. American College of Physicians, Hawaii Regional Meeting. At: Hilton Hawaiian Village Hotel Contact: Nadine C. Bruce, M.D. FACP, 2230 Liliha, Honolulu, Hawaii 96817, (808) 547-6497.
March 17-19, 1982	Gen. Pediatrics. Am. Acad. of Pediatrics 1801 Hinman Ave. Evanston, Ill. 60204. At: Royal Lahaina Resort Maui, 15 hrs.
March 29-April 2 1982	Current Concepts in Ob-Gyn. UH John A. Burns School of Medicine, 1960 East-West Road, Honolulu, Hawaii 96822, At: Ilikai Hotel, Honolulu, Hawaii 20 hrs.
April 19-24, 1982	Diagnostic & Therapeutic Skills in Internal Med. USC Sch. of Med. Postgrad Div. 2025 Zonal Ave., Los Angeles, Calif. 90033, At: Mauna Kea Beach Hotel, Kamuela, 30 hrs.
April 25-29, 1982	Am Assn of Neurological Surgs. Ann. Mtg., 625 N. Michigan Ave., Chicago, Ill. 60611, At: Sheraton-Waikiki, Honolulu, 40 hrs.

OUT OF STATE

For information on any out-of-state programs or courses, refer to August 4, 1981, Special Issue of JAMA or call the HMA Office.

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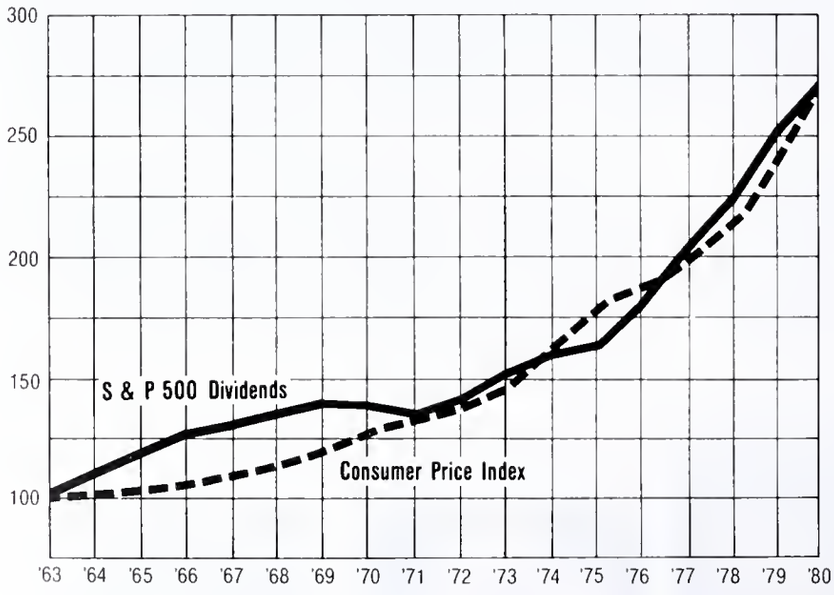
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HMA Council Meeting

Friday, August 7, 1981
320 Ward Avenue

PRESENT:

Drs. Winn, Catts, Lum, Bell, Iaconetti, Fong, Wasson, Chun-Hoon, Morgan, Shirasu, Bruce, Cahill, Fong, Simmons, Wigle, Newman, Goto, Chang, Ostman, Wong, and Sims. HMA staff present were: Messrs. Won, Leineweber, Jones; Mmes. Kendro, Wong, Chang, and Asato.

CALL TO ORDER:

The meeting was called to order by President Winn at 6:10 p.m.

MINUTES:

The minutes of the July 10 meeting and executive sessions of May 1 and June 19 were approved as circulated.

REPORT OF THE SECRETARY:

Council reviewed the Report of the Secretary as of July 31, 1981, which showed that membership totaled 929, as compared with a total of 909 in July 1980. Also reviewed were listings of members who have not completed capital fund payments and members who have been dropped for non-payment of 1981 dues.

REPORTS OF COMMITTEES AND COMMISSIONS:

A. *EMS:* Dr. J.K. Sims presented the results of the "Oahu Critical Care Bed Study" conducted by the HMA-EMS Program in 1979-80. The study evaluates the availability of critical care beds for 10 acute civilian hospitals on Oahu. The results will be presented to the Hospital Association of Hawaii in the near future, and efforts will be made to encourage a continuum of the study.

ACTION:

It was moved, seconded, and passed that HMA strongly encourage the City and County dispatcher to continue to acquire the data on availability of critical care beds; and that HMA strongly encourage the participating hospitals to report the data to the dispatcher in efficient and timely manner.

ACTION:

It was moved, seconded, and passed that the HMA Public Affairs Committee work with the EMS Program to disseminate the information to the media.

Acting EMS Executive Board Chairman Dr. Douglas Ostman reported that the HMA-DOH contract for Fiscal Year 1982, amounting to $613,000, has been approved; and HMA-EMS is currently awaiting receipt of funding. Over the next two months, EMS will train and retrain first responders on Oahu, as well as train MICTs through the State. A search committee has been formed to seek a replacement for the EMS project director. Dr. Livingston Wong has agreed to serve as Acting Project Director in the interim.

Mr. Jon Won reported that the following individuals have agreed to serve as members of the EMS Executive Board:

HMA representatives:
Douglas Ostman
Deborah Putnam
James Penoff
Edward Lipp
Clifford Straehley
Edward Chesne (1st alternate)
Collin Dang (2nd alternate)
HAH representative:
Paul Cook
DOH representative:
John Chalmers

ACTION:

It was moved, seconded, and passed to confirm the appointment of Dr. Douglas Ostman as Chairman, HMA-EMS Executive Board.

B. *Internal Affairs:* Dr. K.Y. Lum presented proposed by-laws amendments as requested by the Executive Committee and prepared by the By-laws Committee. The Council generally agreed with the proposed amendments, with the exception of proposed changes in 4.011 and 5.015, concerning the voting privileges of past presidents on the Council and House of Delegates.

ACTION:

It was moved, seconded, and passed to amend proposed by-laws amendments 4.011 and 5.015 to reflect past presidents' privilege of the floor without a vote.

ACTION:

It was moved, seconded, and passed to approve the proposed by-laws changes, as amended, for circulation to the membership 60 days prior to the House of Delegates meeting.

C. *Medical Education:* Dr. Nadine Bruce brought Council up to date on 1980 Resolution No. 2, re the requirement for mandatory CME for membership in the HMA. While the resolution was not adopted last year, the House recommended that the concept be re-evaluated in the interim for report back at the 1981 Annual Meeting of the House of Delegates. The CME Committee took the issue under study and unanimously recommended that Council support the resolution to rescind the requirement for mandatory CME for membership in the HMA. The Committee pointed out that: (1) AMA has never supported mandatory CME, (2) HMA has always supported voluntary CME, and (3) the requirement for mandatory CME fails to serve the purpose for which it was enacted.

ACTION:

It was moved and seconded that Council support Resolution No. 2 submitted last year regarding rescinding the requirement for mandatory CME for membership in the HMA. The motion failed to pass. There were 9 opposing votes.

D. *MIEC:* Mr. Jon Won reported that HMA has already received 12 applications which have been screened and forwarded to MIEC. Honolulu County Medical Society has decided to assume the responsibility of screening applications and conducting peer review for Honolulu physicians. Non-members in Honolulu County will be assessed an administrative fee of $450 per year for the screening of the application and availability of peer review, a portion of which would be returned to the HMA. Neighbor Island component societies desiring to provide the screening and peer review services would also need to determine an administrative fee. Mr. Won clarified that rejections are handled by MIEC —not by the county society.

E. *Medicaid:* Dr. E. Lee Simmons provided for Council's information, testimony presented by HMA on Medicaid rules and regulations at a DSSH public hearing held in July.

F. *Building:* Mr. Won reported that the HMA building is presently 100% occupied. HMA recently received a response from Ward Estates for renegotiation of the land lease, proposing a land lease rent of $45 per square foot. While the offer is triple the current $15 per square foot valuation, Mr. Won noted that HMA's new office leases include a pass through clause which would allow HMA to pass through such increases to tenants. Ward Estates also indicated that if the offer is not acceptable to HMA, Ward Estates would allow arbitration. Council was briefed on the results of a recent envelope study done of 320 Ward Avenue and was advised of the possible consequences of arbitratrion.

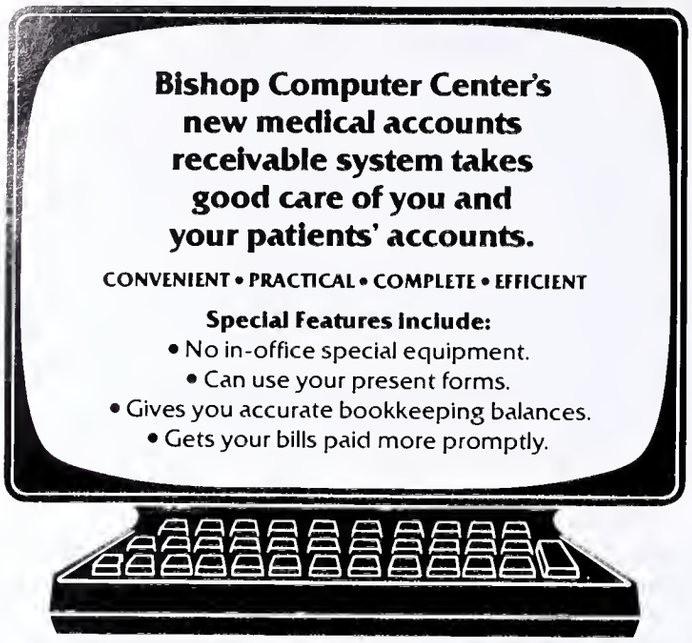
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Names and addresses of Publisher, Editor, and Managing Editor:
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Editar: Horry L. Arnold Jr., M.D. 320 Ward Avenue, Suite 200, Honolulu, Hawaii 96814
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(HMJ Nov. 1, 1981)

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ACTION:
It was moved, seconded, and passed to accept the proposed offer of Ward Estates.

G. *Media Response:* Council discussed the recent editorial, "Physicians as Torturers" which appeared in the Star-Bulletin. It was reported that HMA submitted a rebuttal which was printed in the July 31 Star-Bulletin.

ACTION:
It was moved, seconded, and passed to find the appropriate peer review body of newspaper editors for referral of the subject editorial to request an opinion on whether it is in keeping with standards.

REPORTS OF COUNTY SOCIETY PRESIDENTS

A. *Honolulu:* Dr. Henry Fong reported that HCMS held its last membership meeting on August 3, featuring a program on "Malpractice Pitfalls and Advice." For September, an excellent program has been planned on death and dying in the cancer patient.

B. *Hawaii:* Dr. Arch Wigle reported that Hawaii County will hold its next meeting on August 27. Hilo physicians recently met with a group of Hiroshima doctors who are conducting a study on Hilo residents.

C. *Maui:* Dr. Eugene Wasson reported that the Society's last membership meeting featured an update by Dr. George Mills and Dr. William Iaconetti on the AMA Annual Meeting and HMA Special House of Delegates meeting.

D. *Kauai:* Dr. John Newman, Councilor, reported that the HMA president and executive director made an official visit to the Society on August 4. The Society hosted the dinner which was attended by a number of non-member physicians. Particular interest was expressed on the capital fund proposal which is under consideration.



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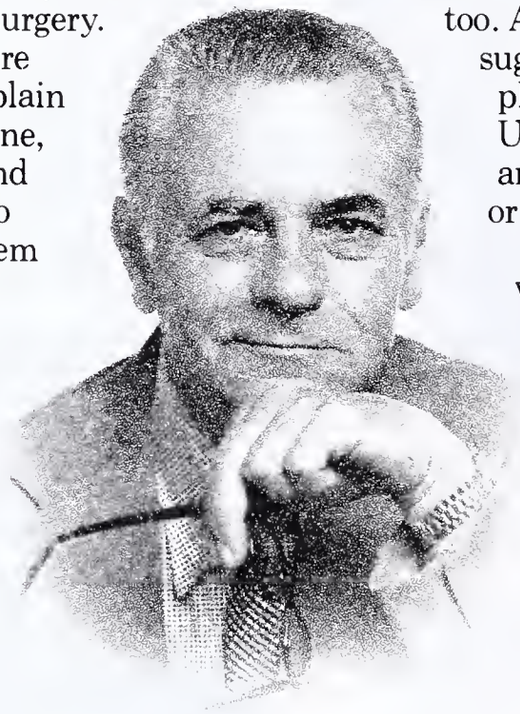
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HMSA Utilization Review Department

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DECEMBER 1981
VOL. 40, NO. 12

Hawaii Medical Journal

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References: **1.** Data on file, Hoffmann-La Roche Inc. **2.** Seppala T, *et al*: *Br J Pharmacol* 3:831-841, 1976. **3.** Harry TVA, Richards DJ: *Br J Clin Pract* 26: 371-373, 1972.

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Skin Cancer and Melanoma: A Report from the Hawaii Cancer Center

Due to the dramatic increase in the incidence of melanoma over the last 20 years among Caucasians (persons of European ancestry) in Hawaii and the continued high incidence of other skin cancers, the Community Cancer Program of Hawaii (CCPH) initiated the Skin Cancer/Melanoma Program (SCMP). The long-range goal of the SCMP, advised by a medical subcommittee which approves all materials and projects developed, is to increase the number of early diagnoses and decrease the incidence and morbidity/mortality rates of skin cancers and melanoma in Hawaii.

One of the SCMP's projects was a statewide survey conducted in February 1981, which included 1,616 Hawaii residents. The purpose of the survey was to obtain, for the first time, baseline information on public knowledge and behavior regarding skin cancer and melanoma, to be used to evaluate the program's public education campaign. The survey was administered on Oahu, Maui, Hawaii, and Kauai through in-person, door-to-door interviews which focused on non-military adults 20 years of age and older. Highlights of this survey are:

Sun exposure: Respondents reported an average of 15.5 hours per week spent in the sun, with a little over 1/3 that time spent from 10 a.m. to 2 p.m., the most hazardous hours for ultraviolet-ray exposure. Reported as the primary reasons for sun exposure were: recreation (65.7%), work (29.1%), and household chores (22.9%). Analysis of the demographic data shows that survey respondents who are of European ancestry, between 20 and 30 years of age, and from households with annual incomes of $35,000 or higher, spend time in the sun primarily for recreational reasons, an above average amount of time, totaling about 16.7 hours per week.



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Preventive behavior: Only 18.6% of those respondents spending time sunning use a sunscreen, and of these sunscreen users, only 35.8% use it daily or regularly. Regular examination of the skin is practiced by 57.5% of the respondents, but only 21.3% had ever asked their doctor to examine their skin for a suspected skin cancer.

Source of skin cancer information: The most widely used source of information about skin cancer is television (cited by 42% of the respondents), followed by doctor (34.8%), magazine (34.2%), newspaper (32.1%), and family or friends (31.7%).

Relationship between knowledge and behavior: A statistically significant, positive relationship was found between knowledge about skin cancer and preventive behaviors. The more knowledgeable respondents were about skin cancer, the more likely they were to use a sunscreen, examine their skin on a regular basis, and ask their doctor to examine their skin for skin cancer. Skin cancer knowledge and the use of protective clothing do not appear to be related.

The results of the survey demonstrate the need to increase public knowledge about skin cancer in order to increase preventive behaviors such as the regular use of sunscreen lotions, regular examination of the skin for changes, avoidance of exposure between 10 a.m. and 2 p.m., and asking a physician to examine suspicious lesions on the skin. The survey further emphasized the use of the television as a major public education-information vehicle, as well as the important role physicians may play in providing information to the public.

An integrated public and professional education campaign has been implemented by the SCMP which includes the use of television and radio public service announcements by Rap Reiplinger, a comic book with artwork by Harry Lyons, distributed with the August 1981 HMJ, and on-going technical training programs developed by and for health professionals. A follow-up survey was conducted in October in Hawaii Kai to evaluate the effect of the comic book. Another statewide survey will be administered in early 1982 to assess public knowledge and behavior. In addition, pre- and post-evaluations of the technical training programs are going on.

DEA's Drug Abusers

The local Drug Enforcement Agency (DEA) has been exceeding its authority in harassing physicians, pharmacists, and their patients. It's time physicians were alerted to protect themselves and to correct this disturbing situation.

In a recent case on Maui, a woman hounded a physician for weeks, demanding tranquilizers, then narcotics, and finally sleeping pills. Although he steadfastly refused her requests, she coaxed his unlisted number from the hospital and badgered him at night. She so doggedly pursued the doctor, and so thoroughly upset his staff, that after a month he finally confronted her: "I'll care for your illness, but I refuse to prescribe any unnecessary pills for you!" At that point she produced her identification: "Congratulations, doc! I'm from the DEA. You passed our inspection!"

This is attempted entrapment of the most vulgar and unconscionable sort, victimizing the healer obliged to relieve distress. One wonders what might have befallen the doctor had he been too exhausted or preoccupied to resist the patient's pleas. Probably he'd be facing a jail sentence along with the Waikiki gynecologist.

In the gynecologist's case, two women were paid by the DEA to pose as patients, lie to the doctor, and entice him to prescribe sleeping pills. After he initially refused, the "patients" persisted, argued, and finally received the prescription they sought. Then the doctor was indicted for prescribing without medical indications.

In the usual DEA routine, the undercover agent tells either a sad story and requests Valium, or a painful story and asks for Percodan, or an insomnia story and seeks sleeping pills. If the doctor provides the prescription, the agent promptly reports to the grand jury, and the indictment follows. There is no preliminary hearing by the Board of Medical Examiners (BME); questions on appropriateness of insomnia therapy or necessity for pain relief are left to the jury.

Now, lest some argue that since "Abscam" this kind of entrapment can be rationalized, let us recall that cash transactions have no place in a legislator's office, while the prescribing of medications is the doctor's obligation. For a federal agent to lie to the physician, plead for drugs, then indict the hapless physician for complying, proves an unspeakable violation of the physician's trust. That this heinous behavior should be perpetrated by a "law enforcement" agency seems inconceivable.

There are reports of DEA agents seizing charts without permission, being rude to office staff, inconsiderate to sick patients, arrogant and hostile to physicians.

Some would justify these capers as necessary to reduce the flow of illicit drugs. But crimes in the name of crime-fighting can never be excused, even though some persons may elect to abuse themselves with drugs. No victims have testified, however, and the magnitude of the danger to society proves elusive. The chief victim of the "crime" of prescribing for undercover agents appears to be the physician himself, as well as the taxpayers who support the masquerade. (And the patients who must look elsewhere, since their doc has gone to jail.)

Many physicians are now tempted to look for a tape recorder in the purse or pocket of anyone seeking controlled substances. Who can justify creating this climate of mistrust? And who will bear the pain of the legitimate patient, denied needed medication by her physician who fears she might be an undercover agent?

In an effort to further reduce drug availability, our DEA has pressured pharmacies not to stock certain medicines, threatening the pharmacist with personal liability, should drugs legally dispensed by him find their way to the black market. What of the needy patient who must now travel further, if he can get his medicine at all? Congress has never granted DEA authority to manipulate local access to legal drugs. If a drug proves sufficiently dangerous, its manufacture and distribution may be halted nationally. In the absence of such restrictions, DEA intimidation of pharmacists and physicians remains unauthorized and illegal.

We pay over $500,000 a year for local DEA "services," and the benefits are difficult to measure. Some physicians allege that the agency has far less interest in catching addicts than in busting several doctors a year, since the latter has proven to be an easier and more effective way for the agency to achieve the publicity which assures continued funding.

In the face of federal spending cuts, the stepped-up physician-entrapment program has an air of "justifying our existence." While there remains a legitimate community role for drug law enforcement, many people question the ethics of violating civil rights in the search for victimless crimes. (It remains unclear, for example, just whom the DEA serves on these witch hunts.) In any event, cases involving medical judgment deserve an initial hearing by the BME.

The best way to remove bureaucractic excesses is to sue them and cut off their funds. We encourage all physicians to report suspected DEA abuses promptly to the HMA. And tell your legislators how you feel about this doctor abuse. By citing these violations of law and authority, we can secure legal redress against the agents, seek a 90% reduction of the agency budget, and demand preliminary BME hearings. Failure to protest to loss of others' freedom invites the theft of our own. A strong stand will serve notice that physicians will not suffer suspension of their civil rights, and that we regard authority abuses as more poisonous to society than drug abuses.

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Depression, Parkinsonism, and Psychosis: A Case Report

CLARENCE E. McDANAL, JR., M.D. *and*
WILLIAM M. BOLMAN, M.D.

The authors present a 40-year-old mentally retarded female, with depression masked by psychosis and Parkinsonism. Psychotropic medications were used to treat the psychosis and Parkinsonism. However, the patient did not make significant progress until psychotherapy and family support were used for her underlying depression. Mental retardates and their families can definitely benefit from psychotherapy. A person with a psychosis and Parkinson-like illness may be suffering from depression which, if treated, could result in an overall improved clinical picture.

Case Report

S.M. is a 40-year-old, single, mentally retarded (I.Q. = 63) Japanese-American woman who had been admitted 5 years earlier to a chronic care institution for the mentally retarded, for control of psychotic behavior and temper tantrums. She was the ninth of 11 children, and had been described as an "easy going" young girl who played mainly with her sibs, who protected her from teasing by other children. The patient repeated the first and third grade, and, after finishing the fourth grade, remained behind in school classes, but reached the ninth grade with special school help and her siblings doing much of her homework.

At home, she had good self-help skills, was a "meticulous" housekeeper, and did many chores, including washing and ironing clothes, washing dishes, and sewing. Later on she helped in the physical care of her father, who had chronic arthritis.

During adolescence, the patient became withdrawn, had episodes of screaming names, and at times appeared to be hearing voices. She required psychiatric hospitalization, but her clinical course continued to deteriorate. Because her parents were elderly and her behavioral problems increasing, the patient was finally committed to an institution for the mentally retarded.

Her father, born in Japan, had moved to Hawaii at age 19, and worked mainly as a carpenter. He was described as a normal, intelligent, quiet man, who enjoyed raising orchids. He died from a stroke at age 88.

Her maternal grandparents were born in Japan, whereas her mother had been born and raised in Hawaii. Her mother was "well-liked," worked as a housewife, enjoyed knitting, and died at 73 of liver cancer.

The patient S.M. had two siblings who had died of early childhood illnesses. All of her 8 living siblings have finished high school and none have required psychiatric care or have been labeled mentally retarded.

In the institution, S.M. was tried on various psychotropic medications, and her clinical course improved so that she could be discharged to a foster home. She adjusted well in this community placement until an older male friend died. Her clinical course then deteriorated, and she was readmitted to hospital. Her mother died 2 months later from cancer. The family did not allow S.M. to attend her mother's funeral "because of her emotional state." Two weeks later, an emergency psychiatric consultation was requested by ward staff because of violent and disruptive behavior. On examination, she was having auditory hallucinations of her mother's, father's, and sister's voices. In addition to being psychotic, she had classic Parkinsonian features, including "pill rolling" tremor in both hands, a fixed or masked facial expression, cog-wheel rigidity of all extremities, diminished swinging of the arms, and a forward-leaning posture with short shuffling

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steps. A neurology consultant diagnosed Parkinsonism, secondary to her psychotropic medications. Medications were changed to trifluoperazine, 10 mg. a day; benztropine mesylate, 2 mg. twice a day, and chlorpromazine, 100 mg. at bedtime. The trifluoperazine was increased later to 40 mg. each morning. Her clinical course did not significantly improve. Five months later, the trifluoperazine was discontinued, and she was given fluphenazine enanthate 12.5-25 mg. intramuscularly every 2 weeks for 5 months; the same benztropine mesylate dosage was continued. The Parkinson features became worse, with increased rigidity and drooling.

Since the clinical picture was now so puzzling, and complicated by the possibility of drug intoxication, all medications were stopped for one month. Her psychosis and Parkinsonian features did not change.

The patient's father then died. The family visited her but were hesitant to tell her about his death. Following this, she became even more psychotic and began striking staff and patients. Again, she was placed on trifluoperazine, 5 mg. twice a day, and benztropine mesylate, 2 mg. twice a day; this time the psychosis and Parkinsonian features partially improved. Therefore, trifluoperzine was increased to 10 mg. twice a day, with further improvements of the psychosis, but no change in the Parkinsonism.

She continued to present ward management problems, and the psychiatric consultant (C.E.M.) decided to explore the possibility that functional factors, namely grief and conflict over the death of her parents, were operative. Because of limited consultant time, a female staff member, who was also Japanese, developed good rapport with the patient. This staff member, with a half-hour of psychiatric consultation per week, discussed with S.M. her feelings and reactions regarding these significant deaths. She told our patient that if she could control her behavior, the staff would take her to visit her parents' graves. After visiting the graves, S.M.'s clinical course improved considerably, to the gratification of all. The staff began taking her to lunch and shopping. The patient's family, including siblings and extended family, also became more involved and added her to their dinners and holiday gatherings. The patient began exchanging letters with sisters and a favorite aunt.

In the institution, she became more appropriately active, doing chores, sewing, watching television, and participating in crafts. This progress continued for a year. She then became paranoid, aggressive, and began hallucinating. Trifluoperazine was discontinued, and the patient was placed on thioridazine, 50 mg. 4 times a day, and was continued on benztropine mesylate, 2 mg. a day. Her psychotic symptoms again decreased, and for 6 months she was functioning as well as before. The Parkinsonian features disappeared to practically none, except a mild hand tremor, made worse by anxiety. She took more interest in personal hygiene and grooming, and progressed in her rehabilitation program.

Discussion

In our opinion, modern psychotherapeutic techniques have been underutilized with mentally retarded people. Simmons, Tymchuck, and Valente state that "traditional psychotherapeutic techniques using dynamic ideas have limited but significant usefulness in two important areas in the care of the mentally retarded: first with the retarded person himself, and second with his parents."[1] Menaloscino states, "the mentally retarded individual thinks and feels like any other person and is prone to similar emotional problems and social difficulties."[2] Our patient demonstrated dramatically that a mentally retarded individual with psychosis and Parkinsonism can benefit greatly from supportive psychotherapy. In addition to the staff's psychotherapeutic approach, the extended family's supportive care contributed to our patient's improvement in working through her grief reaction. It is also of interest to note that this improvement was achieved without the use of antidepressants and electroconvulsive therapy, and was accomplished via the paramedical staff, with limited psychiatric consultation.

Our patient's diagnosis of depression was masked by her Parkinsonism and psychosis. Initial treatment was aimed for the obvious psychosis and Parkinsonian problems. However, with the addition of psychotherapy for her grief reaction, the clinical picture made the most dramatic change.

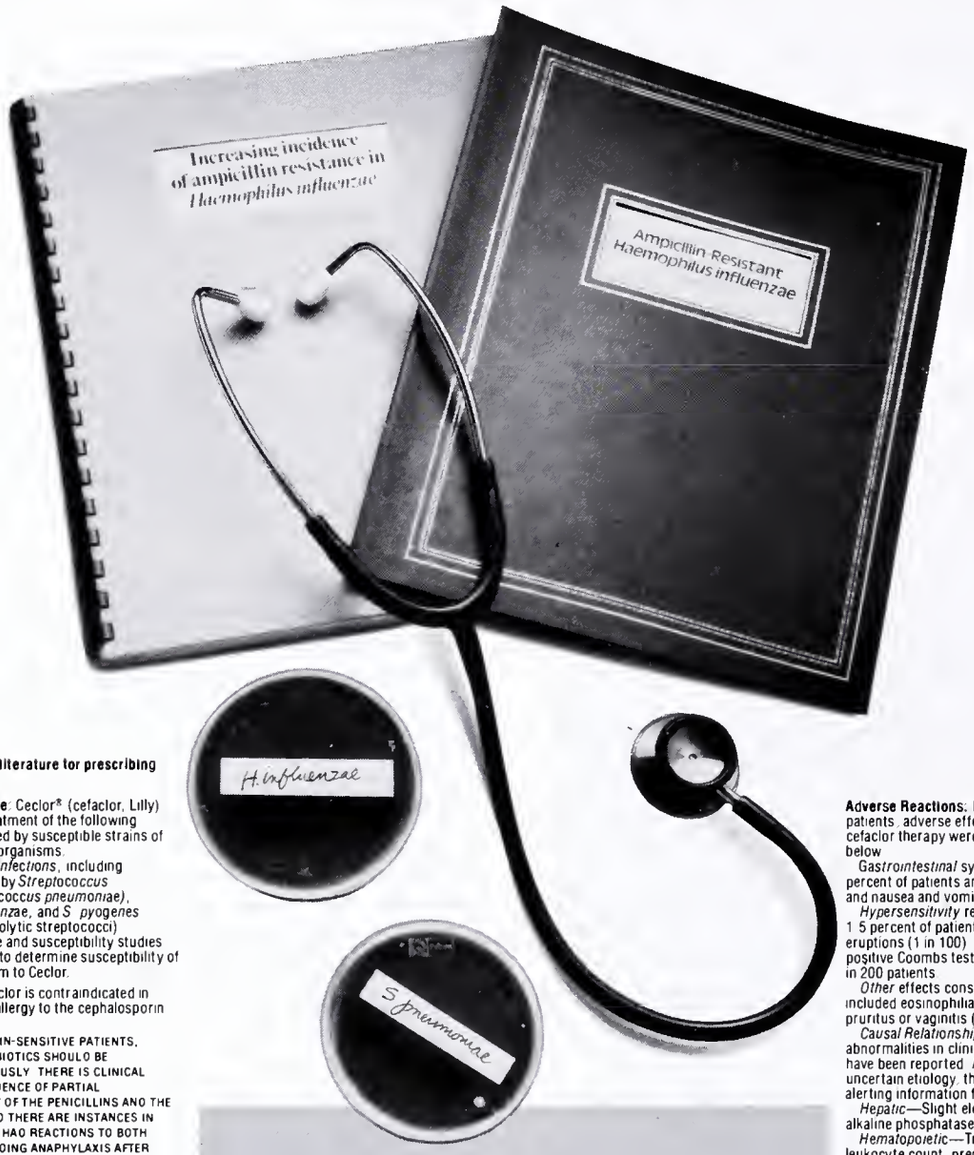
Upon reviewing the literature for other cases to support this opinion, we found several other case reports suggestive that functional or reactive depressive states may play a part in patients with various organic conditions. Lebensohn and Jenkins reported on a 62-year-old man, who had a paranoid depression with Parkinsonism. His mental condition and physical state improved considerably with 4 electroconvulsive treatments.[3] Lipper and Bermanzohn described a 54-year-old woman who was paranoid, suicidal, and had Parkinson's disease. Her mood, psychosis, and Parkinsonian features improved markedly after 7 ECT treatments.[4] Rainey and Faust report that Parkinsonism may be masked by ECT and psychotropic medication.[5] Wilder states that depression may make Parkinsonism worse.[6]

We hope this paper will alert clinicians to look for and treat depression or other psychodynamic factors in patients with mental retardation, psychosis, Parkinsonism and other bio-organic states.

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Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGDT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200). [070379R]

* Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.*

Note: Ceclor* (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Management of Persistent Fetal Circulation in a Neonate

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Persistent fetal circulation is a serious disorder in the neonate, first described by Gersony in 1969 as "persistent physiological characteristics of the fetal circulation in the absence of recognizable cardiac, pulmonary, hematologic, or central nervous system disease."[1] Until recently, therapy for this disorder has consisted of supportive measures. Two therapeutic modalities have recently been described: the intravenous administration of the potent vasodilator, tolazoline hydrochloride; [2] and the use of mechanical hyperventilation.[3] The present case illustrates the successful but complicated treatment of an infant with persistent fetal circulation using a combination of these therapies.

Case Report

Baby D, a 3,366-gram female of 45-weeks gestation, was born by emergency cesarean section for fetal distress, with Apgar scores of 1 and 5 at 1 and 5 minutes, respectively. Resuscitation included intubation, suction of the trachea and positive pressure ventilation. Although the amniotic fluid was meconium-stained, suctioning of the trachea produced scanty clear fluid. The physical examination was initially unremarkable. At 2 hours of age, the infant became tachypneic, although the chest roentgenogram demonstrated no pulmonary or cardiac abnormalities. Blood glucose, hemoglobin, and hematocrit were within normal limits. The infant became progressively more tachypneic, and at 10 hours of age was cyanotic. A capillary blood gas determination showed a pH of 7.20, p02 of 12 mmHg, and pCO2 of 64 mmHg. The infant was intubated and mechanically ventilated in FiO2=1, rate of 120, peak inspiratory pressure (PIP) of 20 cmH2O and positive end expiratory pressure (PEEP) of 4 cmH2O. After insertion of an umbilical artery catheter, blood gas studies showed a pH of 7.32, paO2 of 45 mmHg, and paCO2 of 26 mmHg. A simultaneous determination made on blood from the right radial artery showed a paO2 of 325 mmHg, suggesting persistent fetal circulation. The infant was paralyzed with pancuronium, and mechanical hyperventilation was continued with settings of PIP 30 cmH2O, PEEP=4 cm H2O, rate=100, and FiO2=1.0. In addition, because of the possibility of infection, cultures for sepsis were taken, and the infant was treated with antibiotics. Over the next 18 hours (Figure), these settings maintained the pH between 7.50 and 7.61, and the paCO2 below 30 mmHg. However, the paO2 fluctuated erratically between 21 and 131 mmHg and could not be stabilized with further adjustments in ventilator settings. At 30 hours of age, a peripheral intravenous infusion of tolazoline was initiated at 1 mg/kgm/hr, and increased to 3 mg/kgm/hr while hyperventilation was continued. This was accompanied by an increase in the paO2 from 48 mmHg to 123 mmHg after one hour of therapy. This increase in pa02 was interrupted with the development of systemic hypotension. By 35 hours of age, the mean blood pressure had dropped to 32 mmHg and the pH decreased to 7.32. Hypotension was corrected with IV fluids, blood, and an infusion of dopamine. The metabolic acidosis was corrected with trometha-

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mine. By 45 hours of age, the mean blood pressure had risen to 49 mmHg, the pH rose to 7.58, and the pa02 increased above 150 mmHg. At this time, the infant was in Fi02=1.0, rate of 100, PIP of 36 cmH20, and PEEP of 2 cmH20. At 48 hours of age, the process of weaning the infant from the ventilator was initiated. This process continued into the 6th day, the infant resumed spontaneous respirations and was subsequently extubated. The infant further recovered uneventfully and was discharged. At 9 months of age, she had no apparent respiratory, visual or neurological sequelae.

Discussion

Persistent fetal circulation, a pathophysiological disorder recognized with increasing frequency in the neonate, is associated with high mortality and morbility. This disorder results in a clinical spectrum of abnormalities, ranging from a transient period of cyanosis to a period of more prolonged or unremitting cyanosis, leading to acidosis, hypotension and death. Associated findings include gestational age greater than 42 weeks,[4] meconium aspiration,[5] congenital diaphragmatic hernia,[6] or any problem that leads to chronic intrauterine hypoxia.[7] The pulmonary vascularity of the fetus and newborn infant responds to hypoxia immediately by vasoconstriction.[8] Prolonged vasoconstriction secondary to chronic intrauterine hypoxia may be responsible for the muscular hypertrophy of the pulmonary resistance vessels found in infants with persistent fetal circulation.[9] Constriction of these hypermuscular arterioles in the neonate can lead to pulmonary vascular hypertension resulting in severe ventilation perfusion defects secondary to the shunting of blood across the foramen ovale and patent ductus arteriosus. Historically, the diagnosis of persistent fetal circulation (PFC) has been made either directly by cardiac catheterization or indirectly by finding large differences in pre- and post-ductal paO2 levels.[10] Recently, the confirmation of the diagnosis of PFC has been aided by the finding of prolonged systolic ejection times by echocardiography.[11]

This case illustrates the problems in managing an infant with persistent fetal circulation. The diagnosis was made due to a high index of suspicion. Aggressive intervenion with both mechanical ventilation and pharmacological agents was important in interrupting the disease cycle early and was responsible for the eventual recovery. However, the sequence of events in this case also illustrates the limited effectiveness of both hyperventilation and tolazoline. During the initial 18 hours of treatment, the infant was hyperventilated to maintain paCO2 levels in the range of 25-30 mmHg. Although this method has been described as producing a dramatic decrease in pulmonary artery pressure and alveolar — arterial oxygen differences in infants with persistent fetal circulation,[3] it produced only a transient elevation in paO2 in this infant. While mechanical hyperventilation was maintained, the systemic vasodilator, tolazoline, was then administered. This temporarily resulted in an elevated but still labile paO2, with the development of systemic hypotension and a metabolic acidosis. Systemic hypotension has been described as a complication of tolazoline therapy in the treatment of persistent fetal circulation, and may accentuate the difference between pulmonary and systemic arterial pressure.[2, 12] This can result in an increase in the right to left shunt and a decrease in the paO2. The metabolic acidosis, probably the result of systemic hypoperfusion, may further worsen the clinical picture by directly increasing pulmonary artery pressure.[8] It was only after the subsequent correction of the infant's hypotension that the paO2 stabilized. It was then possible to begin weaning the infant from the ventilator.

The care of the infant with persistent fetal circulation represents a great challenge to neonatologists, because these infants require moment to moment adjustments in therapy. Constant attention to blood pressure and blood volume must be particularly stressed. Although each has limitations, both mechanical hyperventilation and tolazoline have their place in treatment. We recommend combining therapies in those infants with persistent fetal circulation resistant to either therapy alone.

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HMA Auxiliary

The Auxiliary to the Honolulu County Medical Society convened its Annual Guest Day Program at the Hibiscus Ballroom of the Ala Moana Hotel on November 5, 1981. The theme was "Ethno-Medicine: Crossing Cultures to Improve Health Care."

Keynote Speaker was **Senator Pat Saiki**, Chairman of the Senate Higher Education Committee, Conference Day Chair was **Dr. Ann Catts**, President-elect of the Hawaii Medical Association. Some of the other distinguished speakers and panelists were: **Dr. Victor H. Li**, President of the East-West Center; **Dr. Donald Char**, Student Health Services; **Dr. Neal E. Winn**, President of the Hawaii Medical Association; **Dr. Daniel S. Sanders**, Dean of the School of Social Work; and **Dr. Mary Amundson** from the School of Nursing. Concerns of the community were expressed by **Mr. James Swenson, Mr. Albert Yuen, Ms. Ah Quon McElrath**, and many others.

The Program explored the role of language and cultural understanding in health care and the responsibility of the education community in its training of future health care workers. The Program was co-sponsored by the University of Hawaii. Conference chairman was **Priscilla Ching Chung**; Co-chairman was **Sharon Morton.**

Isobel Dvorsky and The Auxiliary Factor

By Dennis L. Breo *

She comes quickly to her point: "We are ready to be discovered."

The organization is the AMA Auxiliary, formerly the "ladies' auxiliary," and its current president, Isobel Dvorsky (Harry S.) of San Leandro, Calif., says both the auxiliary's image and mission have changed.

"As the AMA and state and county medical societies realize the powerhouse potential of the auxiliary," Mrs. Dvorsky said, "I believe we will see more cooperation and involvement. We want to be equal partners with the physicians, doing and sharing programs and projects that can benefit from our talent and expertise. Medical societies can use their auxiliaries much more effectively."

The auxiliary, founded in 1922, clearly has come a long way.

Mrs. Dvorsky notes, "It was almost 60 years ago that a small group of physicians' wives got together to ask the AMA's permission to form an organization to 'extend the aims of the medical profession through the wives of doctors to the various women's organizations which look to the advancement in health and education, to assist in entertainment at all medical conventions, and to promote acquaintanceship among doctor's families so that closer fellowship may exist'."

Mrs. Dvorsky ticks off some accomplishments of today's auxiliary:

- "The pioneering of major community health programs, notably homemaker services, child abuse prevention, health careers recruitment, drug crisis centers, child safety. In 1980 alone, 6,667 community health programs were implemented by the auxiliary to benefit Americans young and old.
- "The maintaining of the auxiliary Project Bank, a magnificent tool that is unique in scope and value. Health projects started throughout the auxiliary's 1,000 counties are stored and shared.
- "The promoting of our national Shape Up for Life campaign. In our first two years, we started programs to help people improve their nutrition and physical fitness. This year, we are expanding the campaign to include mental fitness, particularly the management of stress. We will have special emphasis on the joys and stresses of the medical marriage. Also, for years our national immunization awareness campaigns have helped guard people's health.
- "The expanding of our traditional efforts in areas of prime importance to the medical profession — raising funds through the AMA Education and Research Foundation to help medical students and medical schools; educating people about health care costs and the need for cost containment; representing a positive image of physicians in their communities; and lobbying for sound health legislation.

"The truth is," she said, "that the auxiliary is enormously powerful. As physicians' spouses, we have a very special ability to lead others in matters that relate to health because we have channels for getting information, finding out what needs to be done, and helping to motivate others to act. We have people power in our 81,000 members and in their families and friends whom they influence.

"As government struggles to balance budgets by cutting services, including medical services," Mrs. Dvorsky said, "I see the auxiliary stepping in and helping fill those needs. The auxiliary should be the cornerstone of community health efforts. As government funds for medical education diminish, I see the auxiliary helping fill that need by intensifying its fund-raising efforts."

To the auxiliary president, the volunteer organizations are the backbone of America. "Voluntarism is the very spirit of this nation," she says. "I think that recent reports of the decline in voluntarism may be a result of the tendency to use government services as a substitute for individual and collective action on a direct and personal scale. We allow problems to develop — in families, work, and neighborhoods — and when these problems reach crisis proportions, we hand them over to the state and federal governments and say, 'Here, you deal with it; it's too much for us.'

"This way of thinking must be reversed, and it must be reversed by working through the tens of thousands of voluntary associations — the churches, charitable organizations, private colleges and schools, research institutions, professional societies, women's groups, business and labor, and farmers' organizations. Herbert Hoover long ago stated the warning: 'If these voluntary activities were ever to be absorbed by government agencies, this civilization would be over. Something neither free nor noble would take its place'."

In medicine, Mrs. Dvorsky is determined that voluntarism and the auxiliary will prevail. Her priorities as president are to increase the organization's membership and its programs."

As for membership, she says, "The auxiliary is the best bargain in town. For $11 annual dues, a physician's spouse gains access to a democratic organization that sets policies and carries out programs that benefit every community in this country. Joining is never a matter of dues, but a matter of priority. We need to convince physicians' spouses that joining the auxiliary should be high on their list of priorities."

As for doing more, the auxiliary's new leader cites three programs. "We need to become more involved with the spouses of medical students and residents. These young people are our future. We need to do more to assure good health legislation. We must not only provide information on health bills, but also establish legislative alert systems, plan days at the legislature, hold workshops, and stir our members' interest."

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"I LIKE YOU TOO, JACK - [illegible] FRED."

Excerpted from "Facets," an AMA Auxiliary publication

* National Affairs Editor, American Medical News

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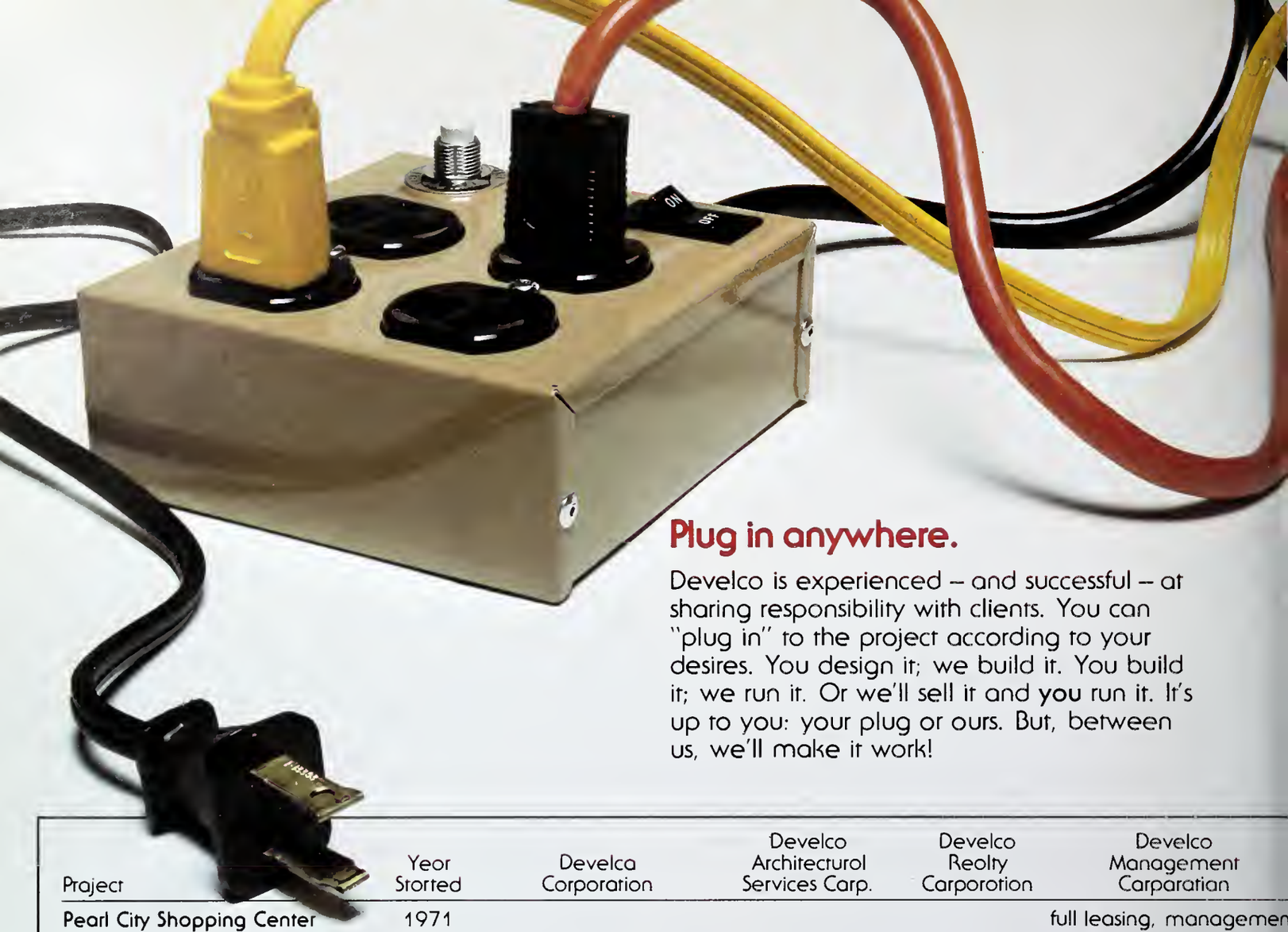
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Kamaole Nalu 36-unit candaminium	1972	joint venture, coordinatar	full service		finoncing
Lele Pono 300-unit candaminium	1973	joint venture, caardinator	full service	sales	
Kanai A Nalu 80-unit candaminium	1975	develaper	full service	sales	finoncing
Sovereign 48-unit candaminium	1977	develaper	full service	sales	financing, management
Kaimuki Shopping Center	1978		full service		
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The Park at Pearlridge 416-unit candaminium	1979		full service	sales	
The Seashore apartment canversian	1979			sales	management
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Over the Editor's Desk

HARRY L. ARNOLD, JR MD

The AMA and General Telephone & Electronics have entered into a long-term agreement to develop and operate an electronic medical information system which can be used by physicians and hospitals through a computer terminal on their telephone line. In many instances, existing computers will make the new system available. For some, a new terminal may be needed. The system is expected to be operational by mid-1982.

* * * * *

The newest (and just FDA-approved) beta blocker for hypertension: Tenormin (atenolol, Stuart Pharmaceuticals). In use abroad since 1976, and given in a single daily dose, it has few if any adverse effects in asthmatics. For further information, call (212) 752-6500 and ask for Barbara Bickel, or write Dr. Norman Kaplan at the University of Texas Health Science Center, Dallas, Texas. Pharmacies should have the drug by November.

* * * * *

Travelers to East Africa may catch chloroquine-resistant falciparum malaria despite careful prophylaxis, the AMA warns. Not only Africa, but Latin America, India, and Southeast Asia harbor this Plasmodium. Quinine is effective.

* * * * *

Since 1977, Tennessee, Rhode Island, Kansas, Minnesota, West Virginia, North Carolina, and New York have all enacted "child safety" laws for the protection of young children riding in automobiles, requiring "safety seats."

* * * * *

Early FDA approval is anticipated for another implantable plastic intraocular lens, this one made by Coburn Optical Industries, Inc., a subsidiary of Revlon.

* * * * *

A 6-year-old child can do a blood sugar level determination on a drop of blood in 2 minutes with the new RAHC Glucose Tester. In Sydney, Australia, use of this machine reduced hospitalization of 30 diabetic children from 333 days to 54 days over a one-year trial period. Write to Australian Bio Transducers, 21 Mooramba Road, Doe Why, N.S.W., Australia 2099.,

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Grants for research or education in chronic respiratory diseases may be available through the University of Hawaii Leahi Trust. Send a typewritten application and 13 copies to Scientific Review Committee, 245 N. Kukui St., Honolulu 96817. Telephone 537-5966. Limit: $25,000.

* * * * *

Odds for success with the "test tube baby" approach to solving infertility problems are about 1 in 250. See August 7 JAMA for another possible approach.

* * * * *

Marijuana smoking impairs attention, learning, thinking, and driving ability; causes tachycardia; alters brain wave patterns; and with chronic use, causes bronchitis, emphysema, menstrual irregularity with infertility, and lung cancer. So concludes a recent AMA study. We can't prevent it, but perhaps we must try.

* * * * *

Zomax (zomepirac sodium) is an important new analgesic for oral use. It is almost as effective as morphine and induces neither tolerance nor dependence. It reduces fever, and does not promote bleeding. If aspirin and acetaminophen fail or are not tolerated, it may be the next drug to try. See JAMA, July 24/31.

* * * * *

Stick a 15-mm patch of scopolamine (Transderm-V, Ciba) behind your ear and be protected from motion sickness for 3 days! A marvelous invention!

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Human chorionic gonadotropin is an unmitigated and ineffective fraud when used to enhance weight loss, AMA investigators have found.

* * * * *

Interested in immunoassay for carcinoembryonic antigen? If so, write to Abbott, Diagnostics Division, Abbott Park, North Chicago, Ill. 60064. It may be the only indicator of recurrence of a cancer of the GI tract, breast, lung, ovary, or pancreas.

* * * * *

A new double-bevelled-tip, silicone-coated, radiopaque intravenous catheter with a vented flashback chamber is announced by Abbott.

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IBM announces a new personal computer for a base price of $1,565, to be sold through IBM Product Centers and Sears new business machine stores. Like the $15 funeral (casket, hearse, and gravedigging extra), it will run you nearer $3,000 for the complete set-up, or $4,500 if you want color graphics, two diskette drives, and a printer. But it certainly sounds like a bargain!

* * * * *

A symposium on head and neck cancer will be held March 5 and 6 in Miami, Fla., for 13 CME credit hours, under sponsorship of the University of Miami School of Medicine, Bo 016960, Miami, Fla. 33101.

* * * * *

A symposium on current concepts in otolaryngology will be held March 3 and 4 under the same auspices. Like the surgical one, it lasts a day and a half.

* * * * *

A new self-adhering absorbent but waterproof and bacteria-proof drape, called Steri-Drape No. 1099, is offered through 3M, Box 33600, St. Paul, Minn. It is 22½ by 26 inches.

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A free 40-page booklet, Office Productivity: The Strategies of Filing, is available from Sharon Kutzel, Supreme Equipment & Systems Corp., 170 53rd St., Brooklyn, N.Y. 11232.

* * * * *

Two sensitive tube tests for early diagnosis of pregnancy — NEOCEPT and UCG-BETA-STAT — are compared in a study you can obtain by writing Organon Diagnostics, 375 Mt. Pleasant Ave., West Orange, N.J. 07052. Ask for their Tech-Line Bulletin on infectious mononucleosis, too, and information on their new Pregnosticon Slide Test kit, for testing for HCG.

* * * * *

Write to 3M, Medical Products Division, Dept. ME81-28, Box 33600, 3M Center, St. Paul, Minn. 55133, for information on their new conductive-adhesive-coated sterile 10-inch electrodes for application alongside surgical incisions to control postoperative pain.

* * * * *

G. Weber et al. report (*Arch Dermatol Research* 270:361, 1981) complete clearing of psoriasis in 8 consecutive cases as a result of lowering the invariably high blood levels of human growth hormone by giving IV somatostatin (not available here), or oral bromocriptin (available), or both. Clearing was complete in 2 to 4 weeks, and arthritis improved, too.

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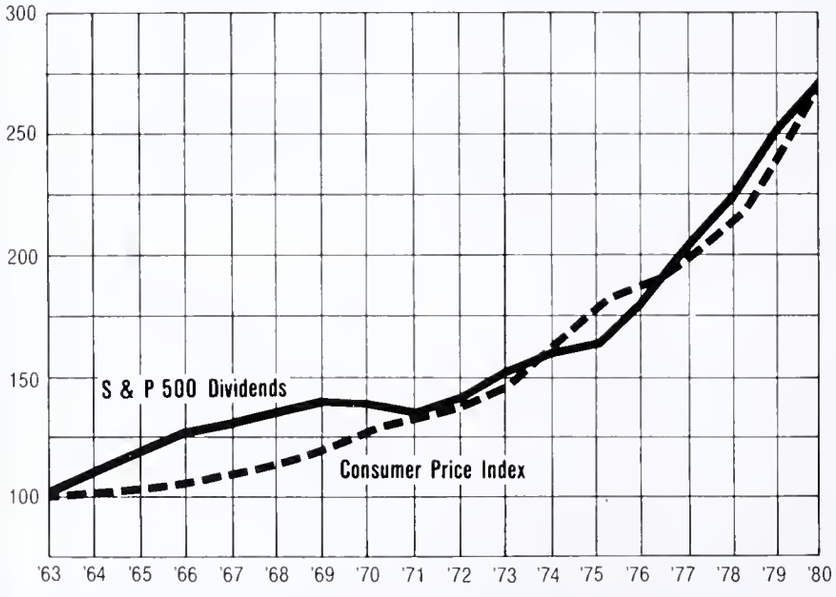
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Hawaii Academy of Family Physicians' Newsletter

Our heartiest congratulations to the Hawaii Medical Association on the occasion of its 125th anniversary!

We have gained two new student members, **Susan Ball** and **Shauna Tseu Williams,** first and second year students, respectively, at UH Medical School. We also welcome a new active member, **Barbara Kobayashi.** She finished her FP residency in Kentucky last year and practices at the Kaiser clinic in Maili.

By the time this goes to print, the Las Vegas meeting will be history; we hope many of you will have enjoyed the program and entertainment. This year, for the first time, the AAFP publicly recognized those physicians who have been members of the Academy for 25 years or more. We congratulate the following members of our chapter who are eligible for this honor: Active members — **W.B. Boone, Cliff Drucker, Robert Freeman, Mary Glover, Harold Merselis, J.I.F. Reppun, Arch Wigle.** Active exempt members — **Masato Mitsuda, David Pang.** Inactive members — **P.H. Liljestrand, Satoru Matsuyama, Arthur Vasconcellos.** Life members — **Homer Benson, Robert Benson, Alfred Burden, D.L. Burlingame, King Chee Chock, James Fleming, Homer Izumi, Robert Millard, Seiichi Miyasaki, Theodore Oto, H.Q. Pang, Varian Sloan, George Tyau, Garton Wall** and **William Walsh. Varian Sloan** is the most senior member, with 34 years of membership. He is closely followed by **William Walsh**, with 33 years.

Our last few dinner meetings have been very successful. We extend a special invitation to those members who have not recently availed themselves of the opportunity to obtain quality "P" credit while enjoying a pleasant social evening with their peers. Please join us! Our next dinner meeting was held November 7 at the home of **Don** and **Marlies Farrell.**

A quick schedule change had to be made for a previous meeting. HMSA had agreed to have a representative speak on payment policy for FPS and to answer members' questions (on previously agreed-to topics). At the last minute we were notified that HMSA had reconsidered and no longer thought it "appropriate" to speak to our group. We wonder what caused this change of heart? Could it be that HMSA is unable or just unwilling to defend its policies before physicians as a group?

We are grateful to **Dr. John Corboy,** spokesman for the Hawaii Federation of Physicians and Dentists, or "Physicians Union," who stepped into the breach to be one of our speakers, instead.

Watch your mail for information on the HAFP Annual Meeting and Seminar in February 1982. The program has been extended to include a cocktail party the evening before the seminar and dinner.

We welcome **Vincent Dang** as a new active member. He completed a family practice residency in California last June and now practices emergency medicine at St. Francis Hospital. Other new student members are **Eric Lichtenberger** and **Gayland Yee**, first- and fourth-year students, respectively. Welcome aboard!

Mark Wentworth on Kauai is looking for an associate, an FP who does OB. Seen in Las Vegas: Former members **Bob Todd, Dave Swanson, Dave Hannan** and **Joe Fitzharris. Varian** and **Erna Sloan** and **Louis** and **Frances Polskin** attended the Congress of Delegates. **Varian** and **Louis** received their 25-year-member pins at a special ceremony. **Don Farrell** presented a research paper during the Scientific Assembly and won first prize in the "practicing physician" category.

As delegates, **Don Farrell** and **Tom Cahill** attended and testified at numerous reference committees and participated in debates on the floor of the congress. **Don** chaired the Reference Committee on Public Policy. Here are some election highlights from the congress: President Elect — **Jerry Gehringer,** Louisiana; Board members — **Angel Mattos,** Puerto Rico, **Robert Taylor,** South Carolina, **Arden Anderson,** Minnesota.

Treasurer's Report: Good news —we're in the black, no national dues increase for 1982!

Actions affecting AAFP members: *Policy on hospital privileges affirmed* —privileges should be based on demonstrated training, experience, and ability of individualM.D.

Lifestyles program to grow and seek outside funds.

Change in Fellowship requirements: Physicians will now need a total of six years as member (active and/or resident) plus 600 hours CME or ABFP.

Other doctors are adopting term "Family Physician": The Board will study and make recommendations on this. We can't copyright the term. Patient education can help.

Goal to increase member ship by 20% in all chapters: That means Us!

Smoking and other risks: A PR campaign to promote healthy living is planned. Congress opposes federal price support for tobacco but declines to favor tax increase.

Breast feeding: Urged for full-term infants in absence of contraindications.

Motorcycle helmet laws: Should be reenacted by states such as Hawaii.

Alcohol-impaired drivers: A deadly public menance which should be removed from our highways. This means us, too!

Hawaii's resolution on nuclear weapons: Adopted as modified — "Resolved, that the medical and allied health professionals of the world be encouraged to join with members of the AAFP in educating our patients to the hazards of nuclear weapons and warfare."

Read your upcoming "Reporters" for more and detailed information on actions of the congress.

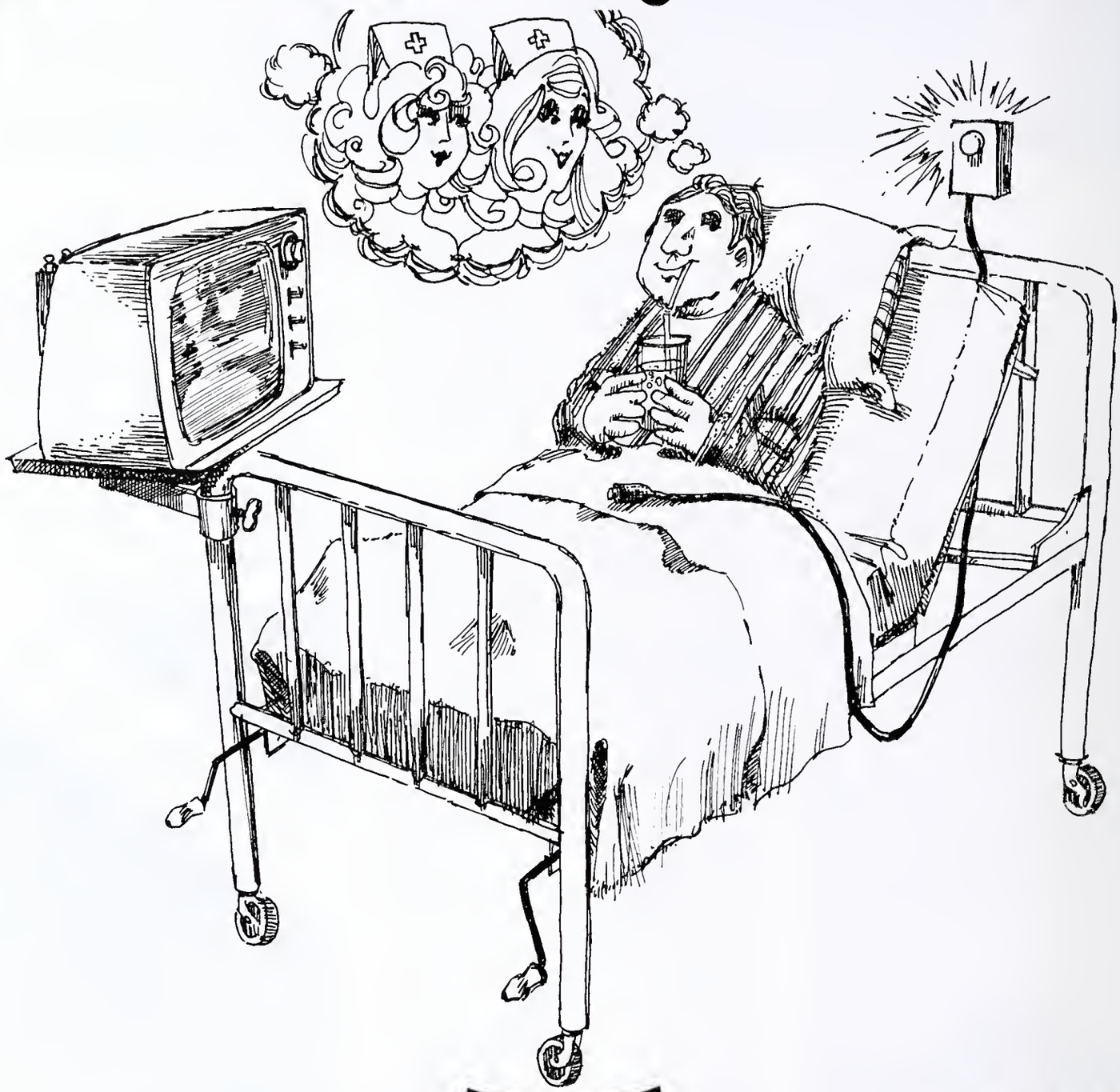
Don't forget to register early for the HAFP Annual Meeting in February.

Happy Holiday!

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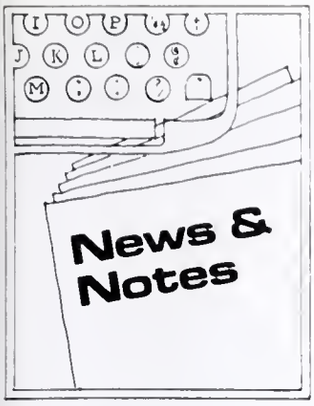
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Professional Moves

We're playing catch-up . . . In late August, pathologists **Paul Tamura** and **Arturo Salcedo** relocated to Pathologists' Medical & Cytology Laboratories, Inc. (PMCL, Inc.) 1010 S. King St., Suite 109A, from 4400 Kalanianaole Highway. Internist **Roy Ebisu** joined **Michael Dimitrion** at the Aiea Medical Building at 99-128 Aiea Heights Drive. Psychiatrist **Bernard Portner** joined Straub Clinic & Hospital, Inc., at 888 S. King St. and plastic surgeon **Guido Lozada** joined **Gunther Hintz's** Plastic Surgery Hawaii, Ltd., at Kuakini Medical Plaza, Suite 601.

In early September, general, thoracic, and cardiovascular surgeon **Allan Inouye** opened his office at Professional Plaza of the Pacific, Suite 502, at 1520 Liliha St. Psychiatrist **Arnold Golden** relocated to the Varsity Building, Suite 511, 1110 University Ave., and fellow psychiatrist **John Ainslie** joined the King Kalakaua Center for Humanistic Psychotherapy, Ltd. Internist-hematologist-oncologist **Jeffrey Nakamura** opened his office at Queen's Physicians' Office Building, Suite 804.

In mid-September, FP **Bernard Kuokoa Chun** joined the Kukui Plaza Medical Associates at 50 S. Beretania St., Suite C-211; radiologist **Richard L. DeJounett** joined the Queen's Physicians Office Building Radiologic Laboratory and gynecologist-family planner **Bernard W. Giorgio** relocated to 98-1238 Kaahumanu St., Suite 200, Pearl City. Urologist **James Dow** relocated to the Professional Plaza of the Pacific and announced the opening of the Honolulu branch office of Uro-Dynamic & Uro-Vascular Laboratory for voiding and erectile dysfunction. Old friend orthopod-sports medicine man **Rowlin Lichter** took pleasure in announcing his association with **Jack Scaff Jr.** and **John Wagner** at Kukui Plaza Medical Associates. Psychiatrist **John Ainslie** announced that he will open offices at the King Kalakaua Center and the Aina Haina Professional Building, Suite 121.

And in late September, FP and sportsmedicine men **Richard You** and **K.C. Yeung** relocated to 205 S. Vineyard St., Suites 204 and 205. OB-gyn man **Ted Tseu** announced the incorporation of his office as that of **Theodore K.L. Tseu**, M.D., Inc., at 1380 Lusitana St., Suite 808.

HMA Tennis Tournament

The annual HMA Doubles Tournament was held on Sunday, Sept. 27, at HICC . . . Thirteen doubles teams were entered and divided into two divisions. The teams played 4 games each until the semi-finals. In one individual play off, **Worldster Lee** and **Dennis Maehara** were bested 6-3 by **Ben Chang** and **Gerard Dericks** . . . In the other play off, **Cal Sia** and **Phil McNamee** upset **Rich Markham** and **Willie Tashima** 6-3. In the finals, **Gerard Dericks** and **Ban Chang** bested **Cal Sia** and **Phil McNamee** 6-1.

In the HMA Singles Tournament open division **Gerard Dericks** beat his doubles partner **Ben Chang** 6-1, 7-5 . . . In the age 50-plus division, **Charley Ching** beat **Raj Mehta** for the championship . . .

Sportsmen

The 7th Annual Kuakini Tee Off for Humanity Invitational Golf Tournament was held on Aug. 26 and 27 at Kunia . . . The first place round-trip tickets to the Big Island with accommodations were won by the threesome of **Glenn Kokame** et al., which scored an incredible 34 under par 108.

St. Francis Golf & Tennis Tournaments

In the St. Francis Hospital annual golf tournament, traditional winner **Bill Dang** was once again the winner . . .

The team of **Cal Sia** and **Ben Chang** won the tennis tournament division A honors while **Walter Y.M. Chang** and **Walter Watt** won division honors . . . **Fortunato Elizaga** won in the beginner's division.

Hors De Combat

"Dr. Harry Arnold, among others, was a bit confused by the new parking garage elevator signs in the Queen's Physicians Office Building. And no wonder — instead of up and down, the arrows point right and left. . . ." (Don Chapman, Aug. 19)

Interesting tidbit: An AP story re: the Dalkon Shield describes "the braided string (attached to the shield) causes a 'wicking' action which allows bacteria to enter the uterus and cause pelvic inflammation, sterility, and even death." (Ed: Imagine that! Here we had thought those vicious looking spokes were to blame)

Charles Odom, the city medical examiner, calls it as he sees it. Charles testified in the case of Daniel Callahan whose stabbed and mutilated body was found in a ditch. Charles testified, "I don't know the cause of death. I can say there were some stab wounds, but they may not be what killed him. The stumbling block is that parts of Callahan's head, neck, and right arm were missing. All that remained of those parts were bones. There may have been some wounds on those parts that could have killed him." Charles did concede, "I am sure he died at the hands of humans because the mutilation could not be attributed to the elements or to animals."

The AMA Coughs Up Its Tobacco Stock: Reacting to embarrassing publicity, the AMA has sold about $1.4 million in tobacco stocks. Chicago physician **Alan Blum** who first raised the issue said, "Selling the stock shows that MDs are putting their money where their mouths are when they preach to their patients about the dangers of smoking."

Ralph Nader group have asked a federal court to halt the sale of hundreds of non-prescription drugs they say contain ingredients of unproven safety or effectiveness. The suit claims that perhaps more than half of all over-the-counter drugs contain ingredients that might be unsafe or ineffective causing wasted consumer spending and potential health risks. The non-prescription drug industry disputed the claims. **Sidney Wolfe,** head of Nader's Health Research Group, said FDA records show 69% of the ingredients reviewed so far lack evidence of safety or effectiveness, or both, and that 49% of those in turn lack evidence of safety alone. Wolf said Americans spend more than $9 billion a year on non-prescription drugs, but only 31% of the drugs' ingredients have definitely been proven safe and effective.

Brenner Lum, a 37-yr-old muscular dystrophy patient has been a patient at St. Francis Hospital for two years at an annual cost to Medicaid of $26,000. Brenner would rather live at home, but DSSH regulations cannot pay the $14,000 a year for a nighttime attendant to hook him up to a respirator at home when he sleeps . . . Brenner claims, "It's a Catch 22 . . . I don't fit into any of their slots . . . I don't fit into anything."

Kenneth Cohen of the Yale School of Medicine wrote in the Journal of the AMA that he could think of few if any reasons for ordering vitamin-level tests. "In those situations where supplemental vitamins are frequently recommended, either owing to decreased intake or increased requirement, such as preganancy, food faddism, or alcoholism, it is usually more practical and less expensive to provide a daily multivitamin tablet than to try to document specific vitamin deficiencies." Biochemist **Myron Brin** of Columbia wrote, "The usual vitamin problem in this country is one of "marginal deficiency' with vague and diverse physicial symptoms such as general malaise, reduced appetite, sleepiness or insomnia, irritability, and reduced attention span . . . (Ed. Funny you should mention those symptoms. We of late, oh well, perhaps we had better double our vitamin intake.)

Baby powder may not be so good for babies. **Howard Mofenson** and **Joseph Greensher** et al. of the Poison Control Center and Department of Pediatrics of the Nassau County Medical Center have written in "Pediatrics" that the practice of using baby powders on young children should be actively condemned until changes are made in their packaging and labeling. They feel that the true incidence of baby powder inhalation is grossly underestimated. Talc or zinc stearate is related to asbestos and medication such as calcium undecylenate, a component of Caldesene (by Pennwalt) may enhance the potential for toxicity. They recommend corn starch instead.

Richard Stenson, Straub Clinic patient care administrator, spoke on a panel of hospital administrators at an Industrial Relations Research Association luncheon meeting in October. Richard offered the following four reasons for the rise in hospital costs which is faster than the general economy:

1—Inflation accounts for more than 50% annually, i.e. supplies, drugs, equipment rise faster than the general inflation. Labor is 60% of the cost.

2—Regulation: In 1977, eight federal regulations alone added $22 to each hospital bill which nationally amounted to $863 million.

3—Demand: In 1955, 21 million patients were admitted; in 1980 36 million. Each year, labor negotiates more health care benefits which has a tremendous impact on health care costs.

4—Innovation and technology: No industry has such technology breakthroughs and while this improves care, it is more expensive.

Richard feels that the solution to rising health care costs might come from innovative plans such as that of the Mendocino County School District in California which provides full medical coverage and offers a $500 annual cash bonus to stay healthy.

The DOH and the advisory board on generic substitutions plan a promotional pro-

(Continued on page 370)



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(Continued from page 369)

gram. In 1980, the Legislature finally passed a law which permits druggists to inform patients that generic equivalents for brand-name drugs are available and it is up to the patient whether to choose the generic product. The program was originally scheduled to get underway to January, but was delayed six months until the advisory board could draft a formulary. The formulary was finally released in June. There is some doubt whether the program will actually save consumers money because some drug stores may be increasing their minimum prices on small prescriptions to make up for the cost of stocking generic drug equivalents.

It seems that Hale Makua, Maui's SNF and ICF facilities in Wailuku and Kahului, has been infested with scabies for at least 4 years. Administrator **Alice Broadhurst** feels that the problem is "blown out of proportion and that people were losing their judgment in hysteria . . . " DOH epidemiologist **Bob Okawa** states that his department has received complaints from patients' families and staff about scabies, but the law outlining his agency's responsibilities does not cover scabies. Bob tells complainants to call Oahu where the Medicare certification officer **Fran Larsen** has not received any calls to date regarding Hale Makua's scabies. (Ed. The old buck passing, eh?) Dermatologist **Gary Salenger** who treats a number of patients at Hale Makua feels that "there is a lot of phobia among the nurses. Every time they itch they think it's scabies." **Jose Romero,** who also treats Hale Makua patients, feels that the Hale Makua program of treatment is effective, that patients now suffering from scabies are well taken care of, and that the workers could be bringing in the recurring disease.

Federal employees received a 4.8% pay raise in October, but health insurance premiums are expected to jump 10% or more next year, thus canceling the raise. Office of Personnel Management Chief **Donald Devine** has notified key members of Congress that the Federal Employees Health Benefits (FEHB) program must take drastic action to avoid even bigger premium jumps — or 30% or more — in plans that cover most of the 9.2 million workers, dependents, and retirees enrolled in the nation's biggest employer-employee health program. (Government pays 60% and employees 40% of the premium costs.)

Pearlridge Hospital first asked for two critical care beds over 2 years ago and was denied by SHPDA. The hospital went the route of the circuit court and was referred back to SHPDA. A recent study conducted by the Hawaii Emergency Medical Services Program concluded that "there is a shortage of criticl care beds in multiple hospitals." Of the 10 hospitals surveyed, Pearlridge was the only one without any critical care beds. (Ed. What! Not even one? No wonder Pearlridge is abegging. Perhaps the new SHPDA administrator, **Ke Nam Kim,** can better listen to reason . . .)

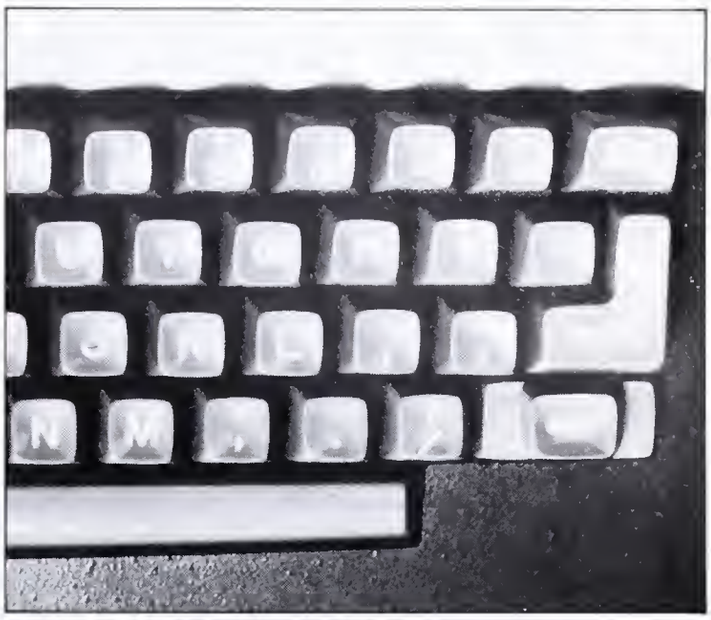
In September, the City Council listened to arguments for and against Castle Hospital's plans for expansion of facilities (esp. a three-story medical office building of doctors, a group including **Joseph Palma, Myron Lezak, Philip Hellreich** and **Donald Hewitt,** are pushing). Physicians opposing the construction of this office building are **Robert Chang, James Mertz** of the Kailua Professional Center, and **Raymond deHay,** partner in the Kai-

(Continued on page 372)

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(Continued from page 370)

lua Medical Arts Building. Three other aspects of the plan — a 40-bed psychiatric unit, a three-story medical-surgical facility and a helipad drew little criticism. . . .

Elected, Appointed & Honored

From the Honolulu Magazine August 1981 issue, we learn that **Max Urata,** neurosurgeon, was nominated for the shaka hall of fame . . . Max reports: "It is a possibility that that shaka sign developed spontaneously in several areas of the Islands. I know how it developed in the Liliha area in the late 1940s, most likely 1947 or 1948. In Kunawai Lane (off Liliha St.) there is a small neighborhood park where the kids of the area congregated. Among them was George (Elephant) Matthews, so named because of his large feet. Elephant, or Ella, as he was affectionately referred to, was a superb body surfer, and played basketball at Farrington High School. (He was, sadly, killed in action in Korea during the police action there.) Ella had a father who liked his beer and frequently abused his children, and as a result, was not well liked by his kids. Mr. Matthews (Ella's father) had lost the middle three fingers of his right hand (I believe it was his right) in an accident. In mimicking his father, Ella used to wave at us with the middle three fingers tucked back (the eventual shaka sign). The wave was given in a special manner, with the arm held at the side, wrist stiff, and hand cocked back (dorsiflexed), with the fingers pointing away from the thigh. The hand then was waggled back and forth, which is the way Mr. Matthews presumably waved . . . "

Anesthesiologist **Efren Baria,** orthopod **Salvador Cecilio,** and pathologist **Arturo Salcedo** were elected new members of the People's Savings & Loan board of directors.

Arnold Siemsen, director of the Institute of Renal Diseases at St. Francis Hospital, has been appointed as one of six voting members of the gastroenterology-urology device section of the General Medical Devices Panel which makes recommendations to the Food and Drug Administration. For the past four years, Arnold has been consultant to the panel which meets in Washington several times a year.

"Leeward boy makes good: **Dr. George Shimomura** of Aiea was elected chief of staff at Kapiolani Hospital for a two-year term." (From Leeward Press)

Ned Wiebenga, DOH chief epidemiologist, reported that measles and rubella have been wiped out in Hawaii. Ned says, "Over the past two years, we've had very low rates of rubella, running less than 50 a year . . . No cases of measles or rubella have been transmitted locally this year . . . What we're faced with now is introduction of measles and rubella by tourists or people traveling here from somewhere else . . . Japan has been a common source of measles cases found here, particularly in light ofa current outbreak in Osaka." So measles and rubella have joined diphtheria, pertussis, and polio on the list of eradicated disease here

Former state senator Ward Russell taped some TV spots for the Red Cross cardiopulmonary resuscitation classes at KHON-TV . . . "Russell's interest in CPR stems from when he suffered a heart attack while jogging, and his life was saved when Dr.

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Sharon Bintliff worked on him for 40 minutes until he had a regular heart rhythm . . ." (From Dave Donnelly's Hawaii column)

The Hawaii Kai Neighborhood Board enthusiastically supported a proposal by Straub Clinic to start a Hawaii Kai health clinic in a second-story roost of the Koko Marina Shopping Center and staffed by two full-time internists and a part-time gynecologist

After years of steady decline, the number of tuberculosis cases has increased in the U.S. and Hawaii's tuberculosis rate remains the highest of all the states . . . But Hawaii officials aren't alarmed. **Herbert Cohen**, chief of the DOH tuberculosis branch, says, "We have been faced with this all along. Hawaii has always had a high rate because of the constant stream of refugees from Southeast Asia and immigrants from other countries . . . Our situation is unique because the number of immigrants is more than 8,000 a year and that is twice that of New York, which has the second highest immigration rate."

Clinical Short Report

'Folate-Induced Remission in Primary Refractory Sideroblastic Anemia'

By Robert T.S. Jim, M.D.

Brand et al reported a young man who recovered from severe chronic aplastic anemia after high dose folate therapy[1] Herein is the report of a 75-year-old Chinese male jeweler with primary refractory sideroblastic anemia since 1978, unresponsive to oxymetholone, pyridoxine, thiamine, steroids, etiocholanolone, lithium and cyclophosphamide. He required 2 units of packed red cells on an average of every 22 days to maintain his hemoglobin from a 6 to 9 gram level, a total of 43 units. On July 19, 1980, he was started on 20 mg of oral folic acid. Since his last transfusion on July 31, 1980, his hemoglobin has gradually increased to 12.7 grams by November 20, 1980. He had goal 111 days without a transfusion.

A possible folate-responsive primary refractory sideroblastic anemia, similar to the folate-responsive aplastic anemia of genetic origin reported by Branda et al, may be present. Such patients may benefit from high dose folate therapy.

Reference

1. Brand, R.F., Moldown, C.F., MacArthur, J.R., Wintrobe, M.M. Anthony, B.K. and Jacob, H.S.: Folate-Induced Remission in Aplastic Anemia With Familial Defect of Cellular Folate Uptake, New England J. of Medicine, 298: 471, 1978.

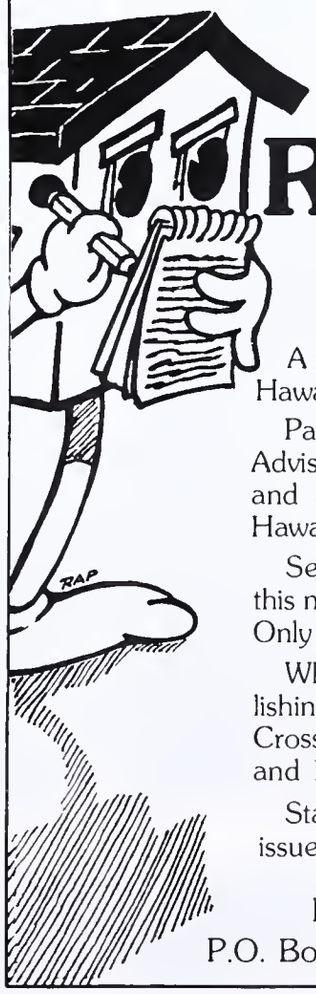
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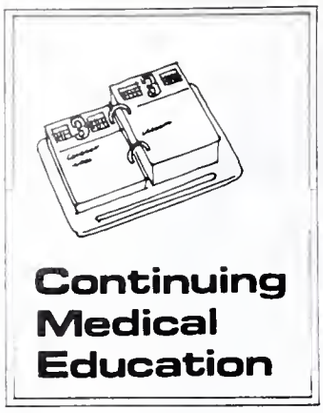
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American Cancer Society, Hawaii Division

1. Telephone Task Force w/G.N. Wilcox Memorial Hospital, First Thursday, 12:45 p.m. and Fourth Tues. 12:30 p.m. w/Maui Mem. Hsp. Held on Oahu at Am. Cancer Society main conf. room, 200 N. Vineyard, Honolulu.

John A. Burns School of Medicine

1. Dept. of Medicine
 - A. Case Conferences, Second and Fourth Tuesdays, 12:30-2:00 p.m., Queen's University Tower, Room 618.
 - B. Grand Rounds, First and Third Tuesdays, 12:30-2:00 p.m., Queen's University Tower, Room 618.
 - C. Endocrinology Grand Rounds, Second Thursday, 5:30-6:30 p.m., Queen's University Tower, Room 506.
 - D. UH-Queen's Conference, Fridays, 8:00-9:00 a.m., Queen's Medical Center, Mabel Smythe Auditorium.
 - E. Cardiology Grand Rounds, First and Third Tuesdays, 5:30-6:30 p.m., Queen's University Tower, Room 508.
 - F. Infectious Disease Grand Rounds, Second and Fourth Tuesdays, 5:00-6:00 p.m., Queen's Nalani I Conference Room.
 - G. Dermatology Grand Rounds, Second Wednesday, 7:30-9:30 a.m., Queen's Medical Center, Queen Emma Clinic.
 - H. Pulmonary Grand Rounds, Fourth Wednesday, 4:30-5:30 p.m., Queen's Medical Center, Kamehamcha Auditorium.
 - I. Nuclear Medicine Grand Rounds, Third Wednesday, 5:00-6:15 p.m., Straub Hospital, Doctors' Dining Room.
 - J. Medical-Surgical GI Grand Rounds, Third Friday, 12:45-1:45 p.m., Kuakini Hospital, PB4 Classroom.
2. Dept. of Obstetrics and Gynecology
 - A. Grand Rounds, Wednesdays, 7:30-8:30 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
3. Division of Orthopedics
 - A. Fracture Conference, Mondays, 5:00-6:00 p.m., Queen's University Tower, Room 618.
 - B. Shriners Hospital Conference, Tuesdays, 7:15-9:00 a.m., Shriners Hospital.
4. Dept. of Pediatrics
 - A. Grand Rounds, Thursdays, 8:00-9:00 a.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 - B. Pediatric Monday Noon Conference, Mondays, 12:45-1:45 p.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
 - C. Pediatric Infectious Disease Conference, Thursdays, 12:30-1:30 p.m., Kapiolani-Children's Medical Center, Conference Room B.
 - D. Perinatal Grand Rounds, Fridays, 8:15-9:15 p.m., Kapiolani-Children's Medical Center, Conference Room B.
5. Dept. of Psychiatry
 - A. Grand Rounds, Fridays, 8:00-9:30 a.m., Queen's University Tower, Room 618.
6. Dept. of Surgery
 - A. Grand Rounds, First, Second, and Third Saturdays, 7:30-9:00 a.m., rotating hospitals.
 - B. Statistical M and M, last Saturday, 7:30-9:00 a.m., rotating hospitals.
 - C. Journal Club, First and Third Tuesdays, 6:00-8:00 p.m., Queen's University Tower, Room 620.
 - D. Medical-Surgical GI Rounds, Third Friday, 12:45-1:45 p.m., Kuakini Medical Center, PB4 Classroom.
 - E. Pediatric Surgical Grand Rounds, First Friday, 12:45-1:45 p.m., Kapiolani-Children's Medical Center, Second Floor Auditorium.
7. Dept. of Family Practice
 - A. Conference, Fourth Wednesday, 1:00-2:00 p.m., Kapiolani-Children's Medical Center, Second Floor Auditorium, Executive Dining Room.
8. Dept. of Family Practice
 - A. Conf., Wednesdays, 8:00-9:00 a.m., Kaiser 4th Floor Conf. Room.
 - B. Conf., Thursdays, 12:00-1:00 p.m., Kaiser 4th Floor Conf. Room.
9. Dept. of Physiology
 - A. Dept. Conf., Wednesday, 4:30-5:30 p.m., BioMed T-210.
10. University of Hawaii, John A. Burns School of Medicine Grand Rounds, Third Thursday, 4:30-6:00 p.m., Queen's University Tower, Room 618 or BioMed Build-Building.
11. HI Oncology Group, one Monday a month, 12:30-1:30 p.m., The Cancer Center, 1236 Lauhala St., 4th Floor Conference Room.
11. HI Oncology Group, Usually Third Monday bimonthly, 12:30-1:30 p.m., The Cancer Center, 1236 Lauhala Street, Fourth Floor Conference Room.
 * Category II.

Federation of Emergency Medicine-Maui

1. **Cardiology for the Emergency Physician.** Every Monday, 9:00-10:00 a.m.-Maui Memorial Hsp. Conf. Rm #1. (For spec. topics or further info contact: Federation Office (808) 244-7629, or Dr. C.T. Mitchell, (808) 244-9056.
2. **Journal Club in Emerg. Medicine.** 2 hrs. Cat. 1. MMH Conf. Rm. #1. 9:00-11:00 a.m.
 12/21/81 Annals in Em Med, 8/81; Abstracts in EM 9/81 - C. Mitchell

Hawaii Thoracic Society

1. Pulmonary Med., Clinical case presentations & current research in pul. med. with U of H Sinclair Chest Club, Third or Fourth Wednesdays, each month, 7:30 a.m.-9:30 p.m. For further info contact: Rosemary Respicio, B.S.N. at (808) 537-5966.

Hickam Clinic

1. Clinical Correlation Conference, First Thursday, 11:00 a.m.
2. Didactic—our staff, Second Thursday, 11:00 a.m.
3. Didactic Visiting Lecturer, Third Thursday, 11:00 a.m.
4. Radiology Conference, Fourth Thursday, 11:00 a.m. (Contact Aurora Macapinlac, M.D., M.C., 449-5770)

Hilo Hospital

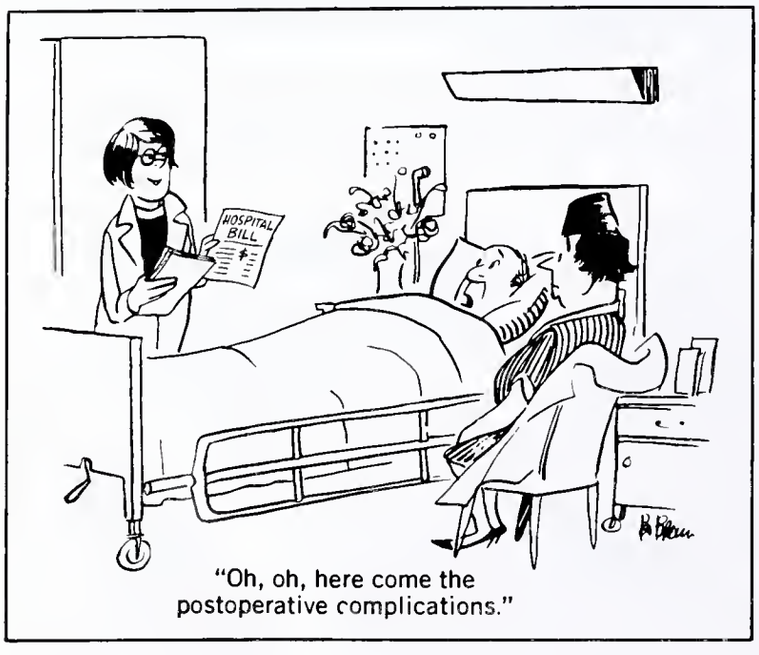
1. Orthopedic Conference, First Tucsday, 12:30-1:30 p.m.
2. NCME (ETV), Thursdays, 12:30-1:30 p.m., Saturdays, 7:00-8:00 a.m. (repeat); not held on long (holiday) weekends.
3. Radiology Case Presentations, Second Wednesday, 12:30-1:30 p.m.
4. Clinical Pharmacology, Third Friday, 12:30-1:30 p.m.
5. C.P.C., Second Friday, 12:30-1:30 p.m.
6. Visiting Professor's Program

Kaiser Hospital

1. Medicine Grand Rounds, Every Tuesday, 8:00 a.m. Pac. Aud. 1 hr. Cat. 1.
2. Tumor Board, Every Tuesday, 12:00 noon. Pac. Aud. 1 hr. Cat. 1.
3. OB/Ped. Perinatal Mortality Conference, Last Tuesday, each month. 8:00 a.m. 1 hr. Cat. 1.
4. Surg. Grand Rounds, Every Friday, 8:00 a.m. Pac. Aud. 1 hr. Cat. 1.
5. Saturday Morning Educational Conference, Every Saturday, 7:30 a.m. Pac. Aud. 1 hr. Cat. 1.

(Contact CME Dept.-Kaiser for further information)

(Continued on page 377)



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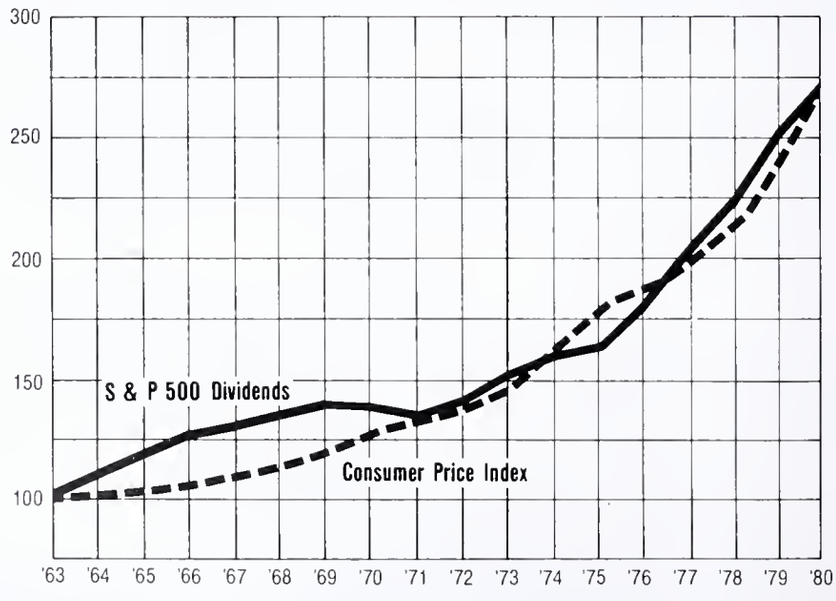
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Hawaii Academy of Family Physicians' Newsletter



Our heartiest congratulations to the Hawaii Medical Association on the occasion of its 125th anniversary!

We have gained two new student members, **Susan Ball** and **Shauna Tseu Williams,** first and second year students, respectively, at UH Medical School. We also welcome a new active member, **Barbara Kobayashi**. She finished her FP residency in Kentucky last year and practices at the Kaiser clinic in Maili.

By the time this goes to print, the Las Vegas meeting will be history; we hope many of you will have enjoyed the program and entertainment. This year, for the first time, the AAFP publicly recognized those physicians who have been members of the Academy for 25 years or more. We congratulate the following members of our chapter who are eligible for this honor: Active members — **W.B. Boone, Cliff Drucker, Robert Freeman, Mary Glover, Harold Merselis, J.I.F. Reppun, Arch Wigle.** Active exempt members — **Masato Mitsuda, David Pang.** Inactive members — **P.H. Liljestrand, Satoru Matsuyama, Arthur Vasconcellos.** Life members — **Homer Benson, Robert Benson, Alfred Burden, D.L. Burlingame, King Chee Chock, James Fleming, Homer Izumi, Robert Millard, Seiichi Miyasaki, Theodore Oto, H.Q. Pang, Varian Sloan, George Tyau, Garton Wall** and **William Walsh. Varian Sloan** is the most senior member, with 34 years of membership. He is closely followed by **William Walsh**, with 33 years.

Our last few dinner meetings have been very successful. We extend a special invitation to those members who have not recently availed themselves of the opportunity to obtain quality "P" credit while enjoying a pleasant social evening with their peers. Please join us! Our next dinner meeting was held November 7 at the home of **Don** and **Marlies Farrell.**

A quick schedule change had to be made for a previous meeting. HMSA had agreed to have a representative speak on payment policy for FPS and to answer members' questions (on previously agreed-to topics). At the last minute we were notified that HMSA had reconsidered and no longer thought it "appropriate" to speak to our group. We wonder what caused this change of heart? Could it be that HMSA is unable or just unwilling to defend its policies before physicians as a group?

We are grateful to **Dr. John Corboy,** spokesman for the Hawaii Federation of Physicians and Dentists, or "Physicians Union," who stepped into the breach to be one of our speakers, instead.

Watch your mail for information on the HAFP Annual Meeting and Seminar in February 1982. The program has been extended to include a cocktail party the evening before the seminar and dinner.

We welcome **Vincent Dang** as a new active member. He completed a family practice residency in California last June and now practices emergency medicine at St. Francis Hospital. Other new student members are **Eric Lichtenberger** and **Gayland Yee**, first- and fourth-year students, respectively. Welcome aboard!

Mark Wentworth on Kauai is looking for an associate, an FP who does OB. Seen in Las Vegas: Former members **Bob Todd, Dave Swanson, Dave Hannan** and **Joe Fitzharris. Varian** and **Erna Sloan** and **Louis** and **Frances Polskin** attended the Congress of Delegates. **Varian** and **Louis** received their 25-year-member pins at a special ceremony. **Don Farrell** presented a research paper during the Scientific Assembly and won first prize in the "practicing physician" category.

As delegates, **Don Farrell** and **Tom Cahill** attended and testified at numerous reference committees and participated in debates on the floor of the congress. **Don** chaired the Reference Committee on Public Policy. Here are some election highlights from the congress: President Elect — **Jerry Gehringer,** Louisiana; Board members — **Angel Mattos,** Puerto Rico, **Robert Taylor,** South Carolina, **Arden Anderson,** Minnesota.

Treasurer's Report: Good news —we're in the black, no national dues increase for 1982!

Actions affecting AAFP members: *Policy on hospital privileges affirmed* —privileges should be based on demonstrated training, experience, and ability of individualM.D.

Lifestyles program to grow and seek outside funds.

Change in Fellowship requirements: Physicians will now need a total of six years as member (active and/or resident) plus 600 hours CME or ABFP.

Other doctors are adopting term "Family Physician": The Board will study and make recommendations on this. We can't copyright the term. Patient education can help.

Goal to increase member ship by 20% in all chapters: That means Us!

Smoking and other risks: A PR campaign to promote healthy living is planned. Congress opposes federal price support for tobacco but declines to favor tax increase.

Breast feeding: Urged for full-term infants in absence of contraindications.

Motorcycle helmet laws: Should be reenacted by states such as Hawaii.

Alcohol-impaired drivers: A deadly public menance which should be removed from our highways. This means us, too!

Hawaii's resolution on nuclear weapons: Adopted as modified — "Resolved, that the medical and allied health professionals of the world be encouraged to join with members of the AAFP in educating our patients to the hazards of nuclear weapons and warfare."

Read your upcoming "Reporters" for more and detailed information on actions of the congress.

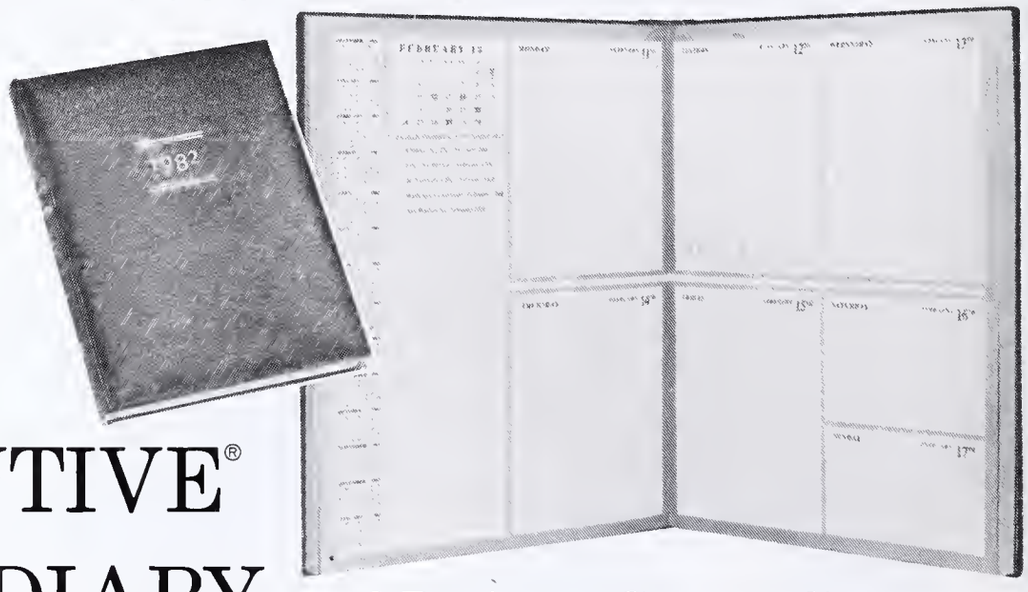
Don't forget to register early for the HAFP Annual Meeting in February.

Happy Holiday!

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(Continued from page 374)

Kapiolani-Children's Medical Center

1. Pediatric Grand Rounds, Every Thursday, 8:00-9:00 a.m., Aud.
2. Pediatric Conference, Mondays, 12:45-1:45 p.m., 2nd Floor Aud.
3. Neonatal Grand Rounds, Friday, 8:00-9:00 a.m., Conference Room B.
4. Pediatric Infectious Disease Conference, Thursdays, 12:30-1:30 p.m., 3rd Floor Conf. Rm.
5. Ob-Gyn Conference, Tuesday, 1:00-2:00 p.m., Aud.
 First—Didactic Presentation
 Second—Perinatal-Neonatal Topics
 Third—Obstetrics Topics
 Fourth—Gyn Topics
6. Tumor Board, Oncology Conference, First and Third Friday, 1:00-2:00 p.m., Aud.

Kuakini Medical Center

1. Department of Ophthalmology Mtg., First Tuesday, 12:30-1:30 p.m.
2. Department of Medicine Mtg. (Statistical), Fourth Tuesday, 1:00-2:00 p.m.
3. G.I. Conference, First Tuesday, 8:00-9:00 a.m.
4. Nephrology Conference, First Wednesday, 8:00-9:00 a.m.
5. Oncology Conference, Every Thursday, 7:30-8:30 a.m.
6. Pulmonary Conference, First Thursday, 1:00-2:00 p.m.
7. Surgical Conference, First & Second Friday, 12:45-1:45 p.m.
8. Surgical M&M Conference, Fourth Friday, 12:45-1:45 p.m.
9. Department of Medicine Evening Mtg., Second Tuesday, 5:30-7:00 p.m.
10. Visiting Professor Program (for further info contact CME Dept. 547-9226 as these programs may be subject to change.)

Maui Memorial Hospital

1. Thursday Conference, 7:00-8:00 a.m., Staff Dining Room.
 First—Dept. of Medicine
 Second—Dept. of Surgery
 Third—Dept. of OB/GYN
 Fourth—Dept. of Pediatrics
 Fifth—Elective
2. Tumor Board, Every Monday, 12:15-1:15 p.m.—Tumor Conference Telephone Task Force—Third Tuesday, 12:15-1:15 p.m.
3. Dept. of Emergency Medicine, Third Monday, 7:00-8:00 a.m.
4. Diagnostic Radiology, Fourth Tuesday, 12:00-1:00 p.m.
5. SFH-UH Hematology Conf., Third Thursday, 12:30 p.m., Sullivan-4 Classroom.
6. SFH-UH Surgical Grand Rounds, First, Second & Third Fridays, 7:30 a.m., Sullivan-4 Classroom.
7. Visiting Professor Programs (for further info call CME office at St. Francis).

Hawaii Ophthalmological Society

1. Monthly dinner meeting, Third Thursday of each month. Contact: Dr. A. Kunimoto, (808) 941-2208.

The Queen's Medical Center

1. ENT Conferences, First and Second Fridays, 7:30 a.m., Small Dining Room.
2. Medical Conferences, Every Friday, 8:00 a.m., Kam Auditorium.
3. Ob/Gyn Conferences, Second and Fourth Mondays, 1:00 p.m., Kam Auditorium.
4. Ophthalmology Conference, Fourth Tuesday, 5:00 p.m., Queen Emma Eye Clinic.
5. Orthopaedic Conferences, Every Wednesday, 7:00 a.m., Kam Auditorium.
6. Pathology Conferences, Every Wednesday, 7:30 a.m., Surgical Conference Room.
7. Pediatric Grand Rounds, Fourth Thursday, 12:30 p.m., Nalani I Conference Room.



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8. Surgical Trauma Conference, Second Tuesday, 4:30 p.m., Kam Auditorium.
9. Basic Science Lectures, Every Wednesday, 7:15 a.m., Queen's University Tower, Room 618.

St. Francis Hospital

1. SFH-UH Tumor Conference, Every Monday, 7:30 a.m., Sullivan-4 Classroom.
2. SFH-UH Nephrology Conference, First Monday, 1:00 p.m., Sullivan-4 Classroom.
3. SFH-UH Endocrine Conference, Last Monday, 12:30 p.m., Sullivan-4 Classroom.
4. EENT Meeting, First Tuesday, 7:00 a.m., Sullivan-4 Classroom.
5. SFH-UH Hematology Conference, Third Thursday, 12:30 p.m., Sullivan-4 Classroom.
6. SFH-UH Surgical Grand Rounds, First, Second & Third Fridays, 7:30 a.m., Sullivan-4 Classroom.
7. Visiting Professor Programs (for further info call CME office at St. Francis).

Straub Clinic & Hospital

1. Straub Professional Seminar meets the Second Tuesday of each month from 5:00-6:30 p.m. in the Credit Union Meeting Room (2nd Floor, Credit Union Bldg.)
2. Surgical Mortality and Morbidity Conference meets every Fourth Thursday of each month, from 7:00-8:00 a.m. in the Doctors' Dining Room.
3. Cardiac Surgery Conference meets the Third Tuesday of each month from 4:30-5:30 p.m. in the Doctors' Dining Room.
4. Department of Anesthesiology meets the Second Tuesday of each month from 7:00-8:00 p.m. in the Doctors' Dining Room.
5. Community Peripheral Vascular Conference meets the Fourth Thursday of each month from 5:00-6:30 p.m. in the Doctors' Dining Room.
6. Visiting Professor Program meets monthly from 7:00-8:00 a.m. in the Doctors' Dining Room.
7. Urology Inservice meets every other month on the Third Friday from 8:00-9:00 a.m. in the Doctors' Dining Room.
8. Neuropathology Clinical Correlation Conference meets the Third Thursday of each month from 7:30-8:30 a.m. in the Straub Morgue.
9. OB-GYN Pathology meets every Fourth Monday of each month from 12:30-1:30 p.m. in the Administration Conference Room (ACR).
10. Urologic Pathology meets every First Monday of each month from 8:00-9:00 a.m. in the Doctors' Dining Room.
11. Friday Noon Conference meets Every Friday of each month from 12:30-1:30 p.m. in the Doctors' Dining Room.

*Note: All conferences are subject to change. Monthly calendar will be available upon request.

Wahiawa General Hospital

1. Noon Seminars, Every Tuesday

Wilcox Hospital (Lihue)

1. General Medical Staff Meeting, Quarterly in January, April, July & October.
2. Clinical Review Meeting, Alternate Mondays at noon.
3. Tumor Conference, First Thursday.

Miscellaneous

HMA Maternal and Perinatal Mortality Study Committee, First Monday each month - 5:30 p.m. 320 Ward Ave., S 200.

Cat. I on hr. for hr. basis.

SPECIAL EVENTS

Dec. 9 12, 1981	9th Annual AMJA Symposium on Endurance Physiology., Hon. Med. Group Res. & Edu. Found., 550 S. Beretania St., Honolulu, Hawaii 96813. At: Moana & Surfrider hotels, Honolulu, 16 hrs.
Dec. 10-11, 1981	The Phys. Role in Quality Assurance & Risk Management, Div. of Quality Control Mgmt., 840 N. Lake Shore Dr., Chicago, Ill. 60611. At: Kahala Hilton Hotel, Honolulu, 10 hrs.
Dec. 12-19, 1981	Phys. Joggers/Hawaii Marathon, U. of Wash. Schl. of Med., SC-50, Seattle, Wash. 98195. At: Honolulu, 8 days.
Jan. 8-15, 1982	Sixth Ann. Echocardiography in Hawaii, Hon. Med. Group Res. & Educ. Found., 550 S. Beretania St., Honolulu, Hawaii 96813. At: Kauai Surf Resort, 30 hrs.
Jan. 9-15, 1982	Gastrointestinal & Hepatic Disease, Hon. Med. Group Res. & Educ. Found., 550 S. Beretania St., Honolulu, Hawaii 96813, 30 hrs.
Jan. 10-15, 1982	Sem. on Gastro-Enterology, UH John A. Burns School of Medicine, 1960 East-West Rd., Honolulu, Hawaii 96822. At: Hyatt Maui, 6 days.

(Continued on page 378)

(Continued from page 377)

Jan. 11-14, 1982	Congress of the Pan Pacific Surg. Assn., Box 553, Honolulu, 96809. At: Sheraton-Waikiki, 2255 Kalakaua Ave., Honolulu, Hawaii 96815, 20 hrs.
Jan. 11-15, 1982	Perinatal Med., USC Sch. of Med. Post Grad. Div., 2025 Zonal Ave., Los Angeles, Calif. 90033. At: Royal Lahaina Hotel Maui, 30 hrs.
Jan. 16-23, 1982	Nephrology, USC Sch. of Med. Postgrad Med., 2025 Zonal Ave., Los Angeles, Calif. 90033. At: Mauna Kea Beach Hotel, Kamuela, 30 hrs.
Jan. 18-20, 1982	Pediatric Emergencies, UH John A. Burns School of Medicine, 1960 East-West Rd., Honolulu, Hawaii 96822. At: Kapiolani Children's Med. Ctr., 1319 Punahou St., Honolulu, Hawaii 96826, 10 hrs.
Jan. 23-30, 1982	Controversies in Emergency Med., UC San Diego, Sch. of Med., Office of Cont. Education, M-017, La Jolla, Calif. 92093. At: Kona Surf, 21 hrs.
Jan. 30-Feb. 6, 1982	Acute Situations in Primary Care, UC San Diego Sch. of Med., Off. of Cont. Educ. M-017, La Jolla, Calif. 92093. At: Wailea Beach Resort, Maui, 21 hrs.
Jan. 30-Feb. 6, 1982	Diagnostic Radiology Sems., UC San Francisco, Dept. of Radiology, Rm. M-396, Third & Parnassus Ave., San Francisco, Calif. 94143. At: Maui Surf Hotel, Maui, 35 hrs.
Feb. 4-5, 1982	American College of Physicians, Hawaii Regional Meeting. At: Hilton Hawaiian Village Hotel, Contact: Nadine C. Bruce, M.D., FACP, 2230 Liliha, Honolulu, Hawaii 96817, (808) 547-6497.
Feb. 6-13, 1982	Cardiology, Univ. of Wash. Sch. of Med., SC-50, Seattle, Wash. 98195. At: Hawaii, 8 days.
Feb. 13-1982	Hawaii Asthma & Allergy Symposium, Hawaii Asthma Camp, YBA, 1710 Pali Hwy., Honolulu, Hawaii 96813. At: Ilikai Hotel, 7 hrs.
Feb. 13, 1982	Hawaii Acad. of Family Phys. Ann. Mtg. & CME Prgm., Hawaii Acad. of Family Phys., 46-378 Holokaa St., Kaneohe, Hawaii 96744. At: Ilikai Hotel, Honolulu, 8 hrs.
March 8-12, 1982	Northwestern Univ. Sports Med. Course, Northwestern Univ. Med. Sch. Ctr. for Sports Med., 303 E. Chicago Ave., 60611. At: Maui, 25 hrs.
March 15-19, 1982	Univ. of Hawaii Sports Med. Course, Univ. of Hawaii Sports Med. Course, Box CED-CCECS, 2530 Dole St., Honolulu, Hawaii 96822. At: Princess Kaiulani Hotel, Waikiki, 18 hrs.
March 17-19, 1982	Gen. Pediatrics., Am. Acad. of Pediatrics, 1801 Hinman Ave., Evanston, Ill. 60204. At: Royal Lahaina Resort Maui, 15 hrs.
March 29-April 2, 1982	Current Concepts in Ob-Gyn, UH John A. Burns School of Medicine, 1960 East-West Road, Honolulu, Hawaii 96822. At: Ilikai Hotel, Honolulu, 20 hrs.
April 3-10, 1982	Topics in Family Prac., U. of Wash. Sch. of Med., SC-50, Seattle, Wash. 98195. At: Hawaii, 8 days.
April 10-17, 1982	Pediatric Emergencies, UC San Diego Sch. of Med., Off. of Cont. Edu., M-017, La Jolla, Calif. 92093. At: Kauai.
Apr. 18-22, 1982	Winter Symp., Am. Coll. of Emergency Phys., Box 61911, Dallas, Texas 75261. At: Marriott's Resort, Kaanapali Beach, Maui, 22 hrs.
April 19-24, 1982	Diagnostic & Therapeutic Skills in Internal Med., USC Sch. of Med., Postgrad Div. 2025 Zonal Ave., Los Angeles, Calif. 90033. At: Mauna Kea Beach Hotel, Kamuela, 30 hrs.
April 25-29, 1982	Am. Assn. of Neurological Surgs. Ann. Mtg., 625 N. Michigan Ave., Chicago, Ill. 60611. At: Sheraton-Waikiki, Honolulu, 40 hrs.
June 19-26, 1982	Fourth Ann. Med. Imaging in Hawaii, Am. Coll. of Med. Imaging, Box 27188, Los Angeles, Calif. 90027. At: Hyatt Regency Hotel, Maui, 24 hrs.
July 13-17, 1982	Endocrine Metabolic Course, USC Sch. of Med. Postgrad Div., 2025 Zonal Ave., Los Angeles, Calif. 90033. At: Mauna Kea Beach Hotel, Kamuela, 25 hrs.
July 17-24, 1982	Cardiovascular Med. & Surg., An Adv. Course, Stanford Univ. Sch. of Med., Stanford, Calif. 94305. At: Mauna Kea Beach Hotel, Kamuela, 22 hrs.

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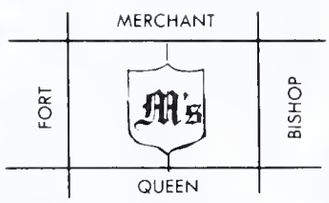
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